



**Their
Futures
Matter**



ACCESS SYSTEM REDESIGN: Evidence Review

21 November 2018

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Glossary

Term	Definition
AbSec	NSW Aboriginal Child and Family Services Secretariat
Access System	The NSW Government committed to a whole of system redesign of the child safety and child wellbeing intake, assessment and referral system – “the Access System”. The objective is to create a multi-agency and evidence-based access system addressing both child protection and child wellbeing need.
ACFC	Aboriginal Child and Family Centres
Active holding	The practice of maintaining regular contact with families waiting to access full services.
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
CARA	Children’s Advice and Referral Alliance (a Tasmanian combined advice and reporting line)
Child and family system	Child and family system’ refers to the NSW system – that is comprised of NSW government agencies, service providers, children and families and communities – that functions to identify, engage and assess, and coordinate services to support the health, safety and wellbeing of children and families.
CWU	Child Wellbeing Unit
Differential response	A multi-track system that allows for a tailored response to child protection concerns according to the identified level of risk.
DFV	Domestic and family violence
Entry	Entry (or contact) refers to the process/s for families to engage with services (government or non-government) and receive an intervention or informal support.
EYC	Early Years Centre (a Queensland community hub model)
FACS	NSW Department of Family and Community Services
FRS	Family Referral Services
IFS/IFP	Intensive Family Support/Intensive Family Preservation
JIRT	Joint Investigative Response Team
Lead professional	The individual responsible for coordinating actions and responses in relation to a child or family in contact with the access system
Localised service	A service that targets and is delivered in only one, or few, geographical locations (as opposed to a service that is delivered state-wide)
MASH	Multi-agency Safeguarding Hub (United Kingdom initiative)
MDT	Multidisciplinary team
NON-ROSH	Where a child or young person has an identified need or risk that does not meet the threshold for risk of significant harm. Service provision is dependent on voluntary participation by the service recipient. Also known as non-Statutory response.
NGO	Non-government organisation
NT	Northern Territory
OOHC	Out-of-home-care
ROSH	A child or young person is at risk of significant harm (ROSH) if the circumstances that are causing concern for the safety, welfare or wellbeing of the child or young person are present to a significant extent. This means it is sufficiently serious to warrant a response by a statutory authority irrespective of a family’s consent. Also known as Statutory response.
SAS2	Secondary Assessment Stage 2 (assessment tool that was used in NSW)
SARA	Safety Assessment, Risk Assessment and Risk Reassessment
SCRPT	Screening and Response Priority Tools (a triage and assessment tool used in NSW) (The SCRPT tools were designed to operationalise the ROSH legislation by defining the ROSH threshold for the various categories and subcategories of harm)
Service	A one-off or ongoing form of support or assistance provided to children and families
TFM	Their Futures Matter

Violence, abuse and neglect	An umbrella term for three types of interpersonal violence that are widespread in the Australian community. This includes all forms of child abuse and neglect, DFV and sexual assault. Based on the NSW Health definition
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Executive Summary

Background

Their Futures Matter (TFM) is a New South Wales (NSW) cross-government reform established to make whole-of-system changes that will better support vulnerable children and families. Our vision is to significantly improve the lives of current and future generations of children and families to give every child has a safe, permanent and loving home.

In August 2016, the NSW Cabinet approved a whole-of-system redesign of the child safety and child wellbeing intake, assessment and referral system – referred to as the 'Access System'. The Access System Redesign aims to better align the needs of vulnerable children and families to responses across the statutory child protection and child wellbeing services.

The TFM Implementation Board approved a three-stage approach for the Access System Redesign in July 2017: high-level design, detailed design and implementation.

This evidence review forms part of the first stage of the Access System Redesign.

About this evidence review

This evidence review identifies and collates evidence from Australia and overseas to inform the Access System Redesign. Rather than duplicate existing evidence, we have collated the significant body of work undertaken to date. Our aim is to develop one central source of evidence to guide the redesign process.

Our review draws on evidence to understand *who the access system should serve and how it should respond to need and risk to improve child and family outcomes*. We have compiled evidence on:

- vulnerability and needs
- the focus of child and family systems and their overlap with other social services systems¹
- models of practice that may be applicable to the NSW context.

We have not provided a cost or demand analysis of the NSW system.

We have drawn from:

- information provided by the TFM project team, developed and collated as part of the Access System Redesign
- evidence suggested by NSW government agencies, particularly related to best-practice Australian and international interventions and approaches to child and family services
- additional research to identify academic and other literature to fill evidence gaps.

There are some limitations to the evidence base (see 0) that must be considered in reading this review. This reflects the challenges of establishing a strong evidence base in an area as complex as child wellbeing and child protection.

¹ In the context of this review, 'child and family system' refers to the NSW system – that is comprised of NSW government agencies, service providers, children and families and communities – that functions to identify and work with vulnerable children and families to support the health, safety and wellbeing of children and families.

Summary of findings

Our review investigated what the evidence tells us about:

- how to understand the needs for family wellbeing and vulnerable families
- what system structure and focus helps to achieve better outcomes for children and families
- how a system should respond to support child and family wellbeing.

Who is vulnerable?

While there is no common view of vulnerability across NSW government agencies, some segments of the population are more likely to experience vulnerability. Identifying them and understanding their needs is essential to a targeted, client-centric access system.

However, the access system and service responses should not be designed around vulnerability alone and should be cognisant of practice models that build on the strengths and assets of individuals, families and communities.

Drivers of vulnerability

The evidence identifies intergenerational trauma and disadvantage as the most significant drivers of long-term and multigenerational reliance on child and family services, particularly statutory responses.

While the evidence on the individual, parental, family and environmental risk and protective factors that drive vulnerability helps to monitor and predict wellbeing, the evidence also tells us that these factors never exist in isolation; certain combinations can rapidly increase the risk of harm and reliance on the statutory system.

Early childhood development

Early childhood has lifelong impacts on health, cognitive, educational and employment outcomes. The evidence shows that it is a significant and modifiable point of change to reduce vulnerability and improve outcomes.

There is some evidence on factors that can mitigate adverse childhood experiences, such as evidence-based, post-first 2000 days (zero to five years old) interventions.

What people need from the child and family system

Evidence shows that segmenting the people who interact with the system gives agencies a common understanding of the general and specific needs of children and families to more effectively target resources to these needs.² We consider this essential in NSW, where multiple agencies - including the Department of Education, Department of Family and Community Services, Ministry of Health, Department of Justice, Department of Premier and Cabinet and NSW Treasury – provide services to meet the diverse service needs of vulnerable children and families.

We have, through existing work, segmented six groups, or sub-populations, based on their level of vulnerability to be able to better understand and determine client needs.

² Kossarova, Devakumar D, Edwards N. 2016. The future of child health services: new models of care. Nuffield Trust. Retrieved from: <https://www.nuffieldtrust.org.uk/files/2017-01/future-of-child-health-services-web-final.pdf>.

Overlap and similarities between child and family systems and other social service systems

It is impossible to isolate the child and family system from overlapping responses. Siloed responses – those that do not look beyond their own portfolio or policy area – do not recognise the common causes, multi-dimensional nature of risks and complexity of needs.

Evidence shows that siloed responses to complex social issues are less effective than collaborative, multiagency responses. Our preliminary analysis of some social services and health responses indicates significant overlap in client needs and some evidence on what works to respond, such as trauma-informed practice.

How a system should respond to support child and family wellbeing

Potential system structures

Typically, child and family systems in Australia and overseas are guided by a child protection-focused framework or a public health-based framework.

A socio-ecological framework translates the public health approach to promote a social services system that focuses on care and wellbeing, rather than only responding to abuse and neglect. Under this socio-ecological framework, efforts can be targeted to individual, families, communities and societies, with a focus on prevention and early intervention.

Core access system components

The evidence on what works to respond to risk and need to improve child and family outcomes is often specific to one program or service. We assessed the evidence of 23 models of practice and six enablers, as shown in Figure 1.

From this, we identified 10 models of practice for which there is a high level of evidence. We have noted where each of these align with the key design elements of the Access System Redesign as outlined in the TFM Consultation Paper:

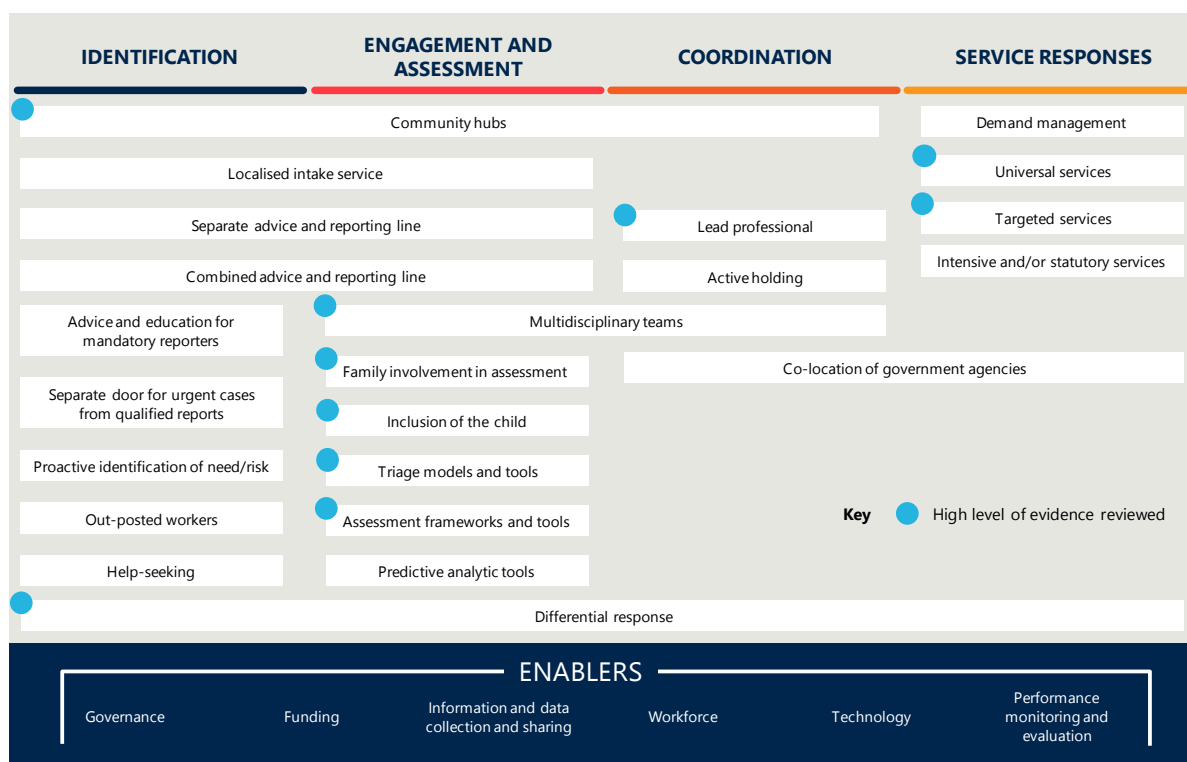
- **Community hubs:** Evidence into community hubs in many jurisdictions indicates a single-entry point that is centrally coordinated and embedded locally within communities and staffed by multi-disciplinary local expertise brings benefits such as better collaboration and better wellbeing outcomes and less pressure on statutory services. Effective community hub models include Aboriginal and Child Family Centres (NSW), Early Years Centres (QLD), The Orange Door (VIC) and Children's Houses (Sweden). *This evidence supports key system element 2: Community Hubs.*
- **Multidisciplinary teams (MDTs):** Successful MDT models include the involvement of child protection and police services, cross-agency case planning, protocols and specialist infrastructure.³ Benefits include better coordination of services and joint accountability for better child outcomes. The Joint Investigative Response Team (JIRT) is a successful MDT program in NSW.⁴ *This evidence supports key system element 3: Multi-agency service coordination.*
- **Family involvement in assessment:** This supports better outcomes and promotes family buy-in to the process.⁵ However, the evidence shows this can be difficult as some families may be involuntary participants or reluctant or unwilling to be involved. *This evidence supports key system element 4: Need is matched to the right response.*

³ NSW Ombudsman, 2017, *The JIRT Partnership – 20 years on: NSW Ombudsman inquiry into the operation of the JIRT program*. Sydney; State of New South Wales.

⁴ NSW Ombudsman, 2017, *The JIRT Partnership – 20 years on: NSW Ombudsman inquiry into the operation of the JIRT program*. Sydney; State of New South Wales.

⁵ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

Figure 1 | Models of practice examined as part of this evidence review



- Inclusion of the child:** Evidence shows that children and young people want and benefit from greater engagement in their own service planning and delivery – their involvement can improve their outcomes.⁶ Frameworks and policies such as *Getting it Right for Every Child* in Scotland or *Signs of Safety* in England have increased child inclusion.⁷ Evidence indicates case workers must have the time to engage, which may require more caseworkers, increased efficiency or longer timeframes to engage. *This evidence supports key system element 4: Need is matched to the right response*
- Triage models and assessment tools:** Evidence is equivocal as to which triage models and assessment tools work best. There is no gold standard tool or approach. A variety of tools are in use; most jurisdictions adapt tools to the specific context. *This evidence supports key system element 4: Need is matched to the right response.*
- Lead professional:** NSW programs with similar functions to a lead professional model include Family Referral Services (FRS), Early Links and Sustaining NSW Families. Results include improved health, safety and developmental outcomes for children and families and better access to services through coordination and the clients understanding more about service availability.⁸ Elements such as the individual's personal skills and attributes, such as expertise in early childhood or child health, influence success. *This evidence supports key system element 1: Early targeted support, advice and case management.*
- Differential response:** Some evidence from other jurisdictions indicates differential response models can support positive outcomes for children and families. For example, models of practice in Victoria have shown that appropriate provision of support can address family needs before statutory

⁶ Bouma H, Lopez M, Knorth E and Grietens H, 2018, *Meaningful participation for children in the Dutch child protection system: A critical analysis of relevant provisions in policy documents*, Volume 79, pp, 279-292. s.l.: Child Abuse and Neglect.

⁷ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

⁸ TFM team summary based on research undertaken as part of the high-level design of the Access System.

intervention is required.⁹ In the US, differential responses show some promising outcomes for children and families, including lower rates of child placement in out-of-home care.¹⁰

- **Universal services:** Literature from Australia and overseas shows universal services such as health and education underpin healthy early childhood development. For vulnerable populations, research indicates that additional support may be needed to ensure people can access universal services, and that universal services provide an opportunity to identify and refer vulnerable children and families to appropriate services.¹¹ The intervention of universal services in the first 2000 days of life can prevent disease and disadvantage and promote positive outcomes for children; more specifically, the first 1000 days is the period of maximum brain development plasticity and has the greatest impact on lifetime outcomes for a child.¹² Home visits to new parents is a popular intervention, with evidence showing some programs have a positive impact on children and mothers. Features of effective programs include skilled workers, a design that addresses the behavioural and psychosocial factors and targeting high-risk families.¹³
- **Targeted services:** High-quality, targeted early intervention can impact developmental outcomes and life trajectories. Successful programs in NSW include Brighter Futures, Early Links, FRS and Sustaining NSW Families.¹⁴ Evidence also shows that Aboriginal-specific positions and the involvement of Aboriginal community-controlled organisations can better reach Aboriginal people and communities. Enablers of success for one model included soft entry points (that is, entering the system without a professional referral) a flexible approach that responds to individual needs, strengths-based approach, community-driven and culturally appropriate design.¹⁵ *This evidence supports key system element 1: Lead professional to support families to access and coordinate multiple services*

Enabling components

Our review also identified enablers - the supporting structures or functions that enable the successful functioning of core access system components:

- **Effective system governance** requires collaboration across government and non-government stakeholders, clear governance structures, transparent reporting and dedicated resources to drive change.¹⁶ A single, whole-of-government planning framework can reduce duplication and support multi-agency collaboration.¹⁷
- **A best-practice funding and investment approach** requires a quantifiable, whole-of-government outcomes framework to increase accountability and inform funding decisions. Structures must ensure cross-agency accountability in funding decisions and a reporting and reallocation cycle that continuously builds and uses evidence to inform funding decisions.¹⁸
- There was limited evidence on **best-practice information and data collection and sharing approaches**. Key themes from reforms in other jurisdictions include investment in centralised mechanisms to manage data and analytics and enabling legislation to support information sharing.¹⁹

⁹ Parenting Research Centre, 2018, *Access system redesign – a rapid evidence assessment of models of triage and segmentation*. Melbourne: Parenting Research Centre.

¹⁰ Ibid.

¹¹ Centre for Community Child Health, 2017, *The first thousand days: an evidence paper*. Melbourne: Centre for Community Child Health.

¹² Centre for Community Child Health, 2017, *The first thousand days: an evidence paper*. Melbourne: Centre for Community Child Health.

¹³ Olds DL and Kitzman H, 1990, *Can Home Visitation Improve the Health of Women and Children at Environmental Risk?* *Journal of Paediatrics* 86(1) 108-116.

¹⁴ Cassells R et al., 2014, *Keep Them Safe Outcomes Evaluation Final Report*. Sydney: NSW Department of Premier and Cabinet.

¹⁵ ARTD Consultants, 2016, *Aboriginal consultation in child protection: Research in the context of evolving understandings and practice*.

¹⁶ Department of Health and Human Services, 2016, *Strong Families – Safe Kids: Implementation Plan 2016-2020*. Hobart: State of Tasmania.

¹⁷ Ibid.

¹⁸ Tune D, 2015, *The Tune Report: Independent review of OOHHC. Appendix 2*.

¹⁹ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

- Benefits of **technology-enabled child and family systems** include timely availability and retrieval of information, standardisation and protection of sensitive information and a greater ability for workers to be accountable.²⁰ Development and implementation of new technologies needs to involve users, promote innovation and build in child-friendliness.²¹
- Evidence shows a **sustainable, skilled workforce** needs ongoing training and professional development, within a well-promoted child protection profession and constructive workplace culture.²² Improving the cultural competency of the workforce often requires Aboriginal workers, greater involvement of Aboriginal community-controlled organisations and greater cultural competency of the whole workforce through training and practice guidelines.²³ *This evidence supports key system element 8: Awareness and capability development.*
- Evidence suggests **effective system performance monitoring and evaluation** requires a logical framework with agreement on the key measures and resources required for monitoring and evaluating programs, supported by funding.²⁴ Consistency with an agreed system-level outcomes framework will better direct efforts and measure results across agencies and service providers.²⁵ *This evidence supports key system element 6: Monitoring and Outcomes Framework for continuous improvement.*

²⁰ Krauter C, 2017, *Child Protection Case Management*. Retrieved from <https://datanova.com.au/child-protection-case-management/>. Kaonga N, Batavia H, Philbrick W, Mechael P, 2016, *Information and Communication Technology for Child Protection Case Management in Emergencies: An Overview of the Existing Evidence Base*. Massachusetts; Procedia Engineering 159, 112-117, Smith R, Eaton T, 2014, *Information and Communication Technology in Child Welfare: The Need for Culture-Centered Computing*. Journal of Sociology & Social Welfare.

²¹ Krauter C, 2017, *Child Protection Case Management*. Retrieved from <https://datanova.com.au/child-protection-case-management/>. Kaonga N, Batavia H, Philbrick W, Mechael P, 2016, *Information and Communication Technology for Child Protection Case Management in Emergencies: An Overview of the Existing Evidence Base*. Massachusetts; Procedia Engineering 159, 112-117, Smith R, Eaton T, 2014, *Information and Communication Technology in Child Welfare: The Need for Culture-Centered Computing*. Journal of Sociology & Social Welfare, 41(1).

²² Lewig K, McLean S, 2016, *Caring for our frontline child protection workforce*. Child Family Community Australia. BaltrUnited Kingdoms D, Hussein S, Montero L, 2017, *Investing in the social services workforce*. Brighton; European Social Network. McArthur M, Thomson L, 2012, *National analysis of the workforce trends in statutory child protection*. Institute of Child Protection Studies. Tune D, 2015, *The Tune Report: Independent review of OOH*.

²³ AbSec, 2016, *Achieving a holistic Aboriginal Child and Family Service System for NSW*. Sydney: AbSec.

²⁴ Ibid.

²⁵ Ernst and Young, 2018, *Access System Redesign – Preliminary User Segmentation*. Sydney: Ernst and Young.

1 Context

Background

Their Futures Matter (TFM) is a NSW cross-government reform with a vision to significantly improve the lives of current and future generations of children and families to give every child a safe, permanent and loving home.

In August 2016, the NSW Cabinet approved a redesign of the child safety and child wellbeing intake, assessment and referral system – referred to as the 'Access System'. The Access System Redesign project aims to better align the needs of vulnerable children and families to responses across the statutory child protection and child wellbeing services.

The TFM Implementation Board approved a three-stage approach for the Access System Redesign in July 2017: high-level design, detailed design and implementation.

This evidence review forms part of stage one of the Access System.

About this evidence review

This evidence review identifies and collates evidence from Australia and overseas to inform the Access System Redesign. Rather than duplicate existing evidence, we have collated the significant body of work undertaken to date. Our aim is to develop one central source of evidence to guide the redesign.

Our review draws on evidence to understand *who the access system should serve and how it should respond to need and risk to improve child and family outcomes*. We have compiled evidence on:

- vulnerability and needs
- the focus of child and family systems and their overlap with other social services systems
- models of practice that may be applicable to the NSW context.

We have not provided a cost or demand analysis of the NSW system.

We have drawn from:

- information provided by the TFM project team, developed and collated as part of the Access System Redesign
- evidence suggested by NSW government agencies, particularly related to best-practice, Australian and international interventions and approaches to child and family services
- additional research to identify academic and other literature to fill evidence gaps

There are some limitations to the evidence base (see 0) that must be considered in reading this review.

This reflects the challenge of establishing a strong evidence base in an area as complex as child wellbeing and child protection.

Review structure

The evidence review considered three lines of enquiry:

- **Section 2:** Understanding vulnerability and need, including:
 - who is vulnerable
 - what drives vulnerability
 - if evidence supports a focus on early childhood development
 - what people need from the child and family system
- **Section 3:** Understanding any overlaps or similarities between child and family systems and other social service systems
- **Section 4:** Understanding how a system should respond to support child and family wellbeing, including:
 - potential system structures
 - models of practice related to the identification, engagement and assessment, coordination and service responses for vulnerable children and families
 - enablers to support a high-performing system.

The Access System Redesign responds to a highly complex issue and is linked to other social issues, such as domestic and family violence (DFV), mental illness and drug and alcohol use. A key challenge is the limited evidence on what works to prevent and respond to child protection and promote child and family wellbeing in Australia and internationally.

We are convinced that successful implementation of the Access System Redesign requires a coordinated commitment from NSW government agencies, combined with regular assessment of new evidence into what works.

2 Understanding vulnerability and need

Key insights

Who is vulnerable?

- There is no common view of vulnerability across NSW government agencies.
- Some sub-populations are more likely to experience vulnerability; identifying them and understanding their needs helps in the design of a targeted, client-centric access system.
- Access and service systems should not be designed around vulnerability alone; service design and delivery should be cognisant of practice models that build on individual's strengths and assets.

What are the drivers of vulnerability?

- Significant evidence exists on the individual, parental, family and environmental risk and protective factors that drive vulnerability; knowledge of these helps to monitor and predict wellbeing.
- Risk and protective factors never exist in isolation; certain combinations can rapidly increase the risk of harm and reliance on the statutory system.
- Intergenerational trauma and disadvantage are the most significant drivers of long-term and multigenerational reliance on child and family services, particularly statutory responses.

What evidence supports a focus on early childhood outcomes to reduce vulnerability?

- Early childhood is a critical period and has lifelong impacts on health, cognitive, educational and employment outcomes.
- Evidence shows that the early childhood period is a significant, modifiable point of change to reduce vulnerability and improve outcomes.
- There is some evidence on factors that help to mitigate the effects of adverse childhood experiences, such as evidence-based post-first 2000 days interventions.

What do people need from a child and family system?

- Segmentation of people who interact with the system allows for agencies to have common understanding of the general and specific needs of children and families, so resources can be effectively targeted to these needs.
- Work undertaken for TFM segmented vulnerable sub-populations into six groups based on their level of vulnerability to be able to better understand and determine client needs.
- Meeting the diverse service needs of vulnerable children and families requires the provision of services from multiple NSW agencies, including the Department of Education, Department of Family and Community Services, Ministry of Health, Department of Justice, Department of Premier and Cabinet and Treasury.

2.1 Who is vulnerable?

Different jurisdictions understand the users and potential users of child and family services through the lens of vulnerability. Evidence indicates vulnerability is often viewed as a culmination of multiple factors that **put a child at risk of harm**, such as:

- **the context in which the family and child exist**, such as the family dynamic; community context; protective and risk factors (see section 2.2)

- **the types and the history of harm in the family**, such as physical, emotional, psychological abuse and neglect; prior history of harm to the child; and prior use of early intervention or statutory services.²⁶

There is no common view of vulnerability across NSW government agencies. The NSW system's historically narrow focus views vulnerability as the 'risk of significant harm', which fails to consider broader risk factors that contribute to vulnerability before families or children are at high risk.²⁷ Agency-specific definitions of vulnerability in NSW typically focus on the subset of vulnerable people within their remit. For example, the Ministry of Health describes a person as vulnerable if there are factors that adversely affect their health outcomes, whereas the Department of Justice describes someone as at risk if there are factors that put them at risk of offending or re-offending. Appendix C details agency-specific and other definitions of vulnerability and at-risk people.²⁸

Differing definitions of vulnerability among agencies that are working towards the same goal, often with the same client base, affects service access and consistency due to the increased risk of subjective judgements and biases, which influences decisions about who requires support.²⁹

A commonly agreed definition of vulnerability will help the Access System Redesign to build future options based on:

- an understanding of what constitutes vulnerability in NSW
- the challenges and needs of at-risk sub-populations.

A shared definition is important in the context of multiagency responses to support integrated, consistent services.³⁰ Figure 2 shows some common elements that help to define vulnerability, based on the NSW Government's definition and other definitions.

Much of the evidence cautions against a focus on vulnerability alone. Alongside vulnerability, effective child and family services consider the **strengths and assets** of individuals, families and communities that allow them to overcome adversity – this is considered essential for triage and assessment.³¹ This is discussed further on page **Error! Bookmark not defined..**

²⁶ Morrone A et al, 2011, Measuring Vulnerability and Resilience in OECD Countries. Paris: OECD, Retrieved from:

<http://www.iariw.org/papers/2011/morronepaper.pdf>; AIFS, 2018, Good and innovative practice in service delivery to vulnerable and disadvantaged children and families. Retrieved from: <https://aifs.gov.au/cfca/publications/good-and-innovative-practice-service-delivery-vulnerable-and-disadvantaged/export>; Boston Consulting Group, 2016, User needs analysis and segmentation. Unpublished.

²⁷ The NSW Interagency Guidelines on Child Wellbeing and Child Protection do not provide a definition for vulnerability but instead define a situation in which there is a risk of significant harm: "A child or young person is at risk of significant harm if the circumstances that are causing concern for safety, welfare or wellbeing of the child or young person are present to a significant extent." FACS. *Child Wellbeing & Child Protection – NSW Interagency Guidelines*. Retrieved from: www.community.nsw.gov.au/_data/assets/pdf_file/0009/336357/reporting_section.pdf.

²⁸ Boston Consulting Group, 2016, *User needs analysis and segmentation*. Unpublished.


²⁹ AIFS. 2018. *Understanding child neglect*. Retrieved from: <https://aifs.gov.au/cfca/publications/understanding-child-neglect/export>.

³⁰ Boston Consulting Group, 2016, *User needs analysis and segmentation*. Unpublished. AIFS, 2018. *Good and innovative practice in service delivery to vulnerable and disadvantaged children and families*. Retrieved from: <https://aifs.gov.au/cfca/publications/good-and-innovative-practice-service-delivery-vulnerable-and-disadvantaged/export>.

³¹ Brown K. 2012. 'Re-moralising vulnerability'. *People. Place and Policy Online*. 6(1). Lewis et al. 2017. *Family Matters Report*. SNAICC – National Voice for our Children, the University of Melbourne, Griffith University and Save the Children Australia. US Department of Health & Human Services. 2008. An Individualized, Strengths-Based Approach in Public Child Welfare Driven Systems of Care. Technical Assistance and Evaluation Center. Children's Bureau. Retrieved from: <https://www.childwelfare.gov/pubPDFs/strengthsbased.pdf>

Figure 2 | Common elements of definitions of vulnerability³²

Drivers of vulnerability	Risk of harm Exposure to potential harm to physical, psychological and emotional wellbeing from one or more risk factors, including intergenerational trauma and disadvantage.	Lack of protective factors Lack of resilience and inability to anticipate, withstand, and recover from harm caused by risk factors.	Complex needs and/or lack of resources Multiple and complex needs and/or a lack of resources (financial, physical, personal or social) to support wellbeing and family functioning.	Current adverse circumstances Current adverse circumstances which increase the risk of harm, such as loss of the main source of family income.
What are common domains of vulnerability	In care or have left care Health and/or disability Economic circumstances Family circumstances/characteristics Poverty	Educational attainment Involvement in offending and/or anti-social behaviour Experience of abuse/exploitation Unable to achieve or maintain reasonable standard of childhood development First 2000 days of life		
Who experiences vulnerability	Children, young people, families and communities Vulnerability can be experienced by individuals, families and communities. The impact of vulnerability for individuals varies between and within families and communities; some people have overlapping vulnerabilities and are more vulnerable than others.			



Some socio-demographic groups are more likely to experience vulnerability³³ due to one or more risk factors (see Figure 3). Being a part of these groups does not mean a person *is* vulnerable; simply that children and families in these groups are statistically more likely to experience risk factors and may:

- be likely to require support from the system
- have multiple and complex needs
- possibly lack the financial, physical, personal and/or social resources to maintain wellbeing.³⁴

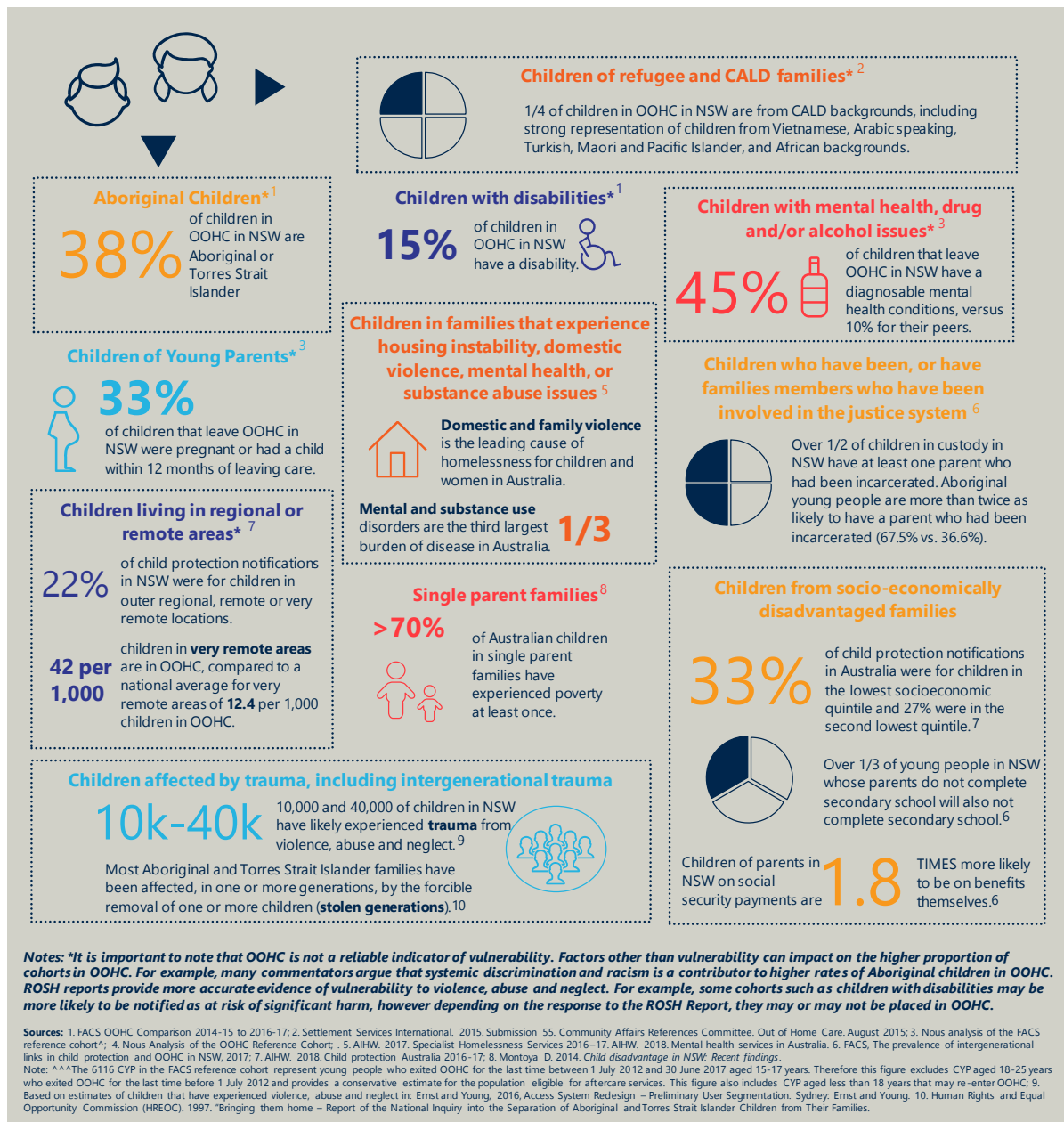
While identifying and understanding the needs of these groups helps in the design of a targeted, client-centric access system, vulnerability should be assessed at the individual level and consider the unique characteristics and circumstances of each child and family.

³² Sources for this figure are provided in Appendix C.

³³ Ernst and Young, 2016, *Access System Redesign – Preliminary User Segmentation*. Sydney: Ernst and Young.

³⁴ Ernst and Young, 2016, *Access System Redesign – Preliminary User Segmentation*. Sydney: Ernst and Young.

Figure 3 | Snapshot of evidence on vulnerable groups cohorts*³⁵



Our research indicates NSW government agencies do not have a full understanding of how many of these at-risk sub-populations of children and families interact with services and their trajectories through the access and service system. There is significant variability in the available data – often it is not collected at all or poorly reported.³⁶

³⁵ Cohorts are selected based on the AIFS and supporting data on vulnerable children and young people. Sources: See diagram for sources of data presented in this diagram; AIFS, Retrieved from: <https://aifs.gov.au/cfca/publications/good-and-innovative-practice-service-delivery-vulnerable-and-disadvantaged>.

³⁶ Boston Consulting Group, 2016, *User needs analysis and segmentation*. Unpublished.

Some researchers and practitioners argue that a child and family system that uses the language of vulnerability to define, identify and support users has limitations.³⁷ The concept of vulnerability focuses on the negative aspects of people's lives, often with limited consideration of the strengths and assets that may help people to overcome vulnerability. **Evidence shows that an effective child and family system considers the unique needs, preferences and strengths of people and communities, rather than solely using 'vulnerability' as a method for client identification and service planning.**³⁸

The evidence shows that:

- **Vulnerability can become a self-fulfilling prophecy**, particularly when children are exposed to a narrative that they, their family and/or their community is vulnerable without a focus on protective factors that increases their resilience to adverse experiences.³⁹
- **Being labelled as vulnerable can be stigmatising and disempowering.** At a micro level, vulnerability is seen as abnormal and can lead to stigmatising and exclusionary behaviours. For example, children are bullied at school for being poor, or family members with financial or alcohol and drug issues are excluded from family gatherings. At a service/system level, vulnerability can be used to justify protectionist policies and actions by non-vulnerable populations over vulnerable groups. This is a common criticism among Aboriginal stakeholders.⁴⁰
- **A focus on vulnerability is counter to a person-centred approach**, if doing so translates to assessment and service responses that do not consider the unique needs, preferences and strengths of individual clients. Some researchers argue that labelling a child as 'vulnerable' can lead practitioners to view the child as a passive recipient of services, which then overrides the preferences of the child and their family.⁴¹
- **A focus on vulnerability is counter to a strengths-based approach**, as efforts are focused on addressing vulnerability rather than leveraging someone's strengths and assets. Research on person-centred, strengths-based approaches shows that designing services around people's needs, preferences and goals, as well as their strengths and assets, can lead to more effective and sustainable outcomes than approaches that focus solely on vulnerability.⁴²
- **The concept of vulnerability is subjective.** Abuse and neglect are not well defined. Assessments of who is vulnerable are influenced by the judgement and biases of practitioners, service providers, policy makers and society. Some researchers argue that biases in conceptions of family, child protection and safety, which are often based on Western conceptions of healthy family functioning, can lead to an over or under assessment of a child's level of vulnerability. These biases may also mean people miss important protective factors, strengths and assets of children, families and communities that could reduce their vulnerability.⁴³

³⁷ Brown K. 2012. 'Re-moralising vulnerability'. *People, Place and Policy Online*. 6(1). Lewis et al. 2017. *Family Matters Report*. SNAICC – National Voice for our Children, the University of Melbourne, Griffith University and Save the Children Australia. Retrieved from: <http://www.familymatters.org.au/wp-content/uploads/2017/11/Family-Matters-Report-2017.pdf>.

³⁸ Ibid; US Department of Health & Human Services. 2008. An Individualized, Strengths-Based Approach in Public Child Welfare Driven Systems of Care. Technical Assistance and Evaluation Center. Children's Bureau. Retrieved from: <https://www.childwelfare.gov/pubPDFs/strengthsbased.pdf>

³⁹ Rak C F, Patterson L E. 1996. 'Promoting Resilience in At-Risk Children.' *Journal of Counseling & Development*. 74(4).

⁴⁰ Brown K, 2012, 'Re-moralising vulnerability'. *People, Place and Policy Online*. 6(1). Lewis et al., 2017, *Family Matters Report*. SNAICC – National Voice for our Children, the University of Melbourne, Griffith University and Save the Children Australia. Retrieved from: <http://www.familymatters.org.au/wp-content/uploads/2017/11/Family-Matters-Report-2017.pdf>.

⁴¹ Daniel, B. 2010. Concepts of Adversity, Risk, Vulnerability and Resilience: A Discussion in the Context of the 'Child Protection System'. *Social Policy and Society*, 9, 2, 231-241. CrossRef link.

⁴² US Department of Health & Human Services. 2008. An Individualized, Strengths-Based Approach in Public Child Welfare Driven Systems of Care. Technical Assistance and Evaluation Center. Children's Bureau. Retrieved from: <https://www.childwelfare.gov/pubPDFs/strengthsbased.pdf>.

⁴³ Lone B and Harris M. 2018. *Triage and Assessment Tools: "Accessing Help through the Front Door"*. Report for the Department of Family and Community Services 'Their Futures Matter' Access System Redesign. University of New England. Unpublished.

2.2 Drivers of vulnerability

The evidence considers individual, parental, family and environmental risk and protective factors that drive vulnerability. Risk and protective factors for child safety and protection can be defined as the measurable circumstances, conditions or events that increase or decrease the probability that a child or family may have poor outcomes in the future.⁴⁴ An understanding of these factors can help to:

- recognise an individual's potential level of vulnerability and therefore the likely timing, type and intensity of support required, depending on the type and volume of contributing risk and protective factors for a child or family
- inform the design of prevention and early intervention strategies, based on a holistic understanding of needs and a person or family's unique set of risk factors
- give practitioners a holistic view of family experiences and how these interact, so that they can work with other services as part of a multiagency response.⁴⁵

There are limitations in the research on the association between risk and protective factors and child abuse and neglect:

- empirical research has produced inconsistencies and conflicting findings on the impact of many other risk and protective factors, although there is a consistent link between socio-economic status and child abuse and neglect.
- most research has focused on mothers. The risk and protective factors identified in this research may be less applicable to fathers, other parents and carers.
- most research has focused more on the individual characteristics of the child or parent and less on social and environmental factors.
- research is often unable to demonstrate causality. Some risk factors could be a result of, rather than a cause of, violence, abuse or neglect.⁴⁶

Despite these limitations, we have identified the risk and protective factors that are commonly cited in the literature as a useful starting point for understanding a child's vulnerability, and the services that may be required to improve their wellbeing or prevent them from experiencing violence, abuse or neglect.

Risk factors

There is significant Australian and international evidence on the risk factors that drive vulnerability. Risk factors are considered in terms of:

- individual, family or parental level or social and environmental factors⁴⁷
- either inherent factors that typically relate to financial, personal, physical or social attributes, or circumstantial factors specific to a time or life event.⁴⁸

⁴⁴ AIFS, 2017, *Risk and protective factors for child abuse and neglect*. Published online; AIFS

⁴⁵ Ibid.

⁴⁶ Ibid; Stith, S., Liu, T., Davies, C., Boykin, E., Alder, M., Harris, J. M. et al. (2009). Risk factors in child maltreatment: A meta-analytic review of the literature. *Aggression and Violent Behavior*, 14(1), 13-29.

⁴⁷ Ibid.

⁴⁸ AIFS, n.d., *Good and innovative practice in service delivery to vulnerable and disadvantaged children and families*. Published online, AIFS.

The evidence commonly finds that a child is never to blame for violence, abuse or neglect. The evidence commonly finds that the presence of risk factors does not necessarily result in child abuse and neglect, but they are more likely to exist in families where it does occur.⁴⁹

Table 1 shows the commonly cited risk factors for child wellbeing, safety and protection issues. As above, these risk factors do not cause child abuse or neglect.

Table 1 | Common risk factors for poor child and family outcomes⁵⁰

Individual child factors	Family or parental factors	Social or environmental factors
low birth weight	parental substance abuse	socio-economic disadvantage
pregnancy or birth complications	involvement in criminal behaviour	parental unemployment
child temperament or behaviour	family conflict or violence	housing difficulties or insecure housing arrangements
child disability	mental health issues	lack of access to social support
	history of child abuse and neglect	lack of prenatal care
	large family size	neighbourhood disadvantage or violence
	exposure to stress	intergenerational trauma
	parental temperament	
	teenage or young parent/s	
	low level of parental education	
	unplanned pregnancy	
	chronic or serious physical health issues	
	social isolation	

Protective factors

Protective factors are positive attributes or conditions that reduce the effects of adverse experiences on a child and promote their healthy development.⁵¹ They can assist a child and their family to cope and recover from adverse experiences. Understanding protective factors enables system and service providers to identify and leverage individual, family and community strengths and assets.

Commonly cited protective factors are shown in Table 2.

⁴⁹ Goldman J and Salus M, 2003, *A coordinated response to child abuse and neglect: the foundation for practice*. Washington, US Department of Health and Human Services.

⁵⁰ AIFS, 2017, *Risk and protective factors for child abuse and neglect*. Published online; AIFS. AIFS, n.d., *Good and innovative practice in service delivery to vulnerable and disadvantaged children and families*. Published online, AIFS. Nelson C, Fox A and Zeanah C, 2014, *Romania's Abandoned Children: Deprivation, Brain Development and the Struggle for Recovery* (Summary of book). Cambridge: Harvard University Press. Doyle O, 2017, *The first 2000 days and child skills: evidence from a randomized experiment of home visiting*. UCD Dublin.

⁵¹ AIFS, 2017, *Risk and protective factors for child abuse and neglect*. Published online; AIFS.

Table 2 | Common protective factors for reducing child abuse and neglect⁵²

Individual child factors	Family or parental factors	Social or environmental factors
social and emotional competence attachment to parent/s	strong parent/child relationship parental self-esteem family cohesion two-parent household high level of parental education self-efficacy family functioning knowledge of parenting and child development parental resilience concrete support for parents	positive social connection and support employment neighbourhood social capital adequate housing socio-economically advantaged neighbourhood access to health and social services

Risk and protective factors do not exist in isolation. All children and families experience a combination of risk and protective factors. For most, exposure to risk factors is minimal and protective factors support healthy relationships and child development.

The existence of multiple risk factors has a cumulative effect, increasing the level vulnerability and risk of harm. Children who experience multiple risk factors over a long period are more likely to end up with serious developmental challenges.⁵³

This is particularly true when the following risk factors exist:

1. **The 'toxic trio' of DFV, mental illness and drug and alcohol misuse**, which is the most dangerous in terms of safety and poor child developmental outcomes. Evidence from the United Kingdom showed that among cases where children have been seriously harmed or died (293 cases between 2011 and 2014), DFV was present in 54 per cent of cases, parental mental ill health in 53 per cent and parental alcohol or drug misuse in 47 per cent. No NSW-specific data was identified.⁵⁴ The toxic trio is an example of how the prevalence of multiple risk factors can rapidly increase child or family vulnerability, necessitating targeted responses.⁵⁵
2. **Intergenerational trauma and entrenched disadvantage**, where the existence of one, or both, means people and families are far more likely to require support or intervention and often multiple services, statutory services and over time or for generations. People may be more likely to require support from overlapping systems over time, such as the justice, health, education and other social services system (for example, for DFV or drug and alcohol misuse).

⁵² AIFS, 2017, *Risk and protective factors for child abuse and neglect*. Published online; AIFS. AIFS, n.d., *Good and innovative practice in service delivery to vulnerable and disadvantaged children and families*. Published online, AIFS.

⁵³ Evans, G. W., & Schamberg, M. A. 2009. Childhood poverty, chronic stress and adult working memory. *Proceedings of the National Academy of Sciences*, 106 (16), 6545-6549; Seeman, T., Epel, E., Gruenewald, T., Karlamangla, A., & McEwen, B. S. 2010. Socio-economic differentials in peripheral biology: Cumulative allostatic load. *Annals of the New York Academy of Sciences*, 1186, 223-239.

⁵⁴ Sidebotham et al, 2016, *Triennial analysis of serious case reviews*

⁵⁵ Children's Commissioner, 2018, *A Crying Shame: A report by the Office of the Children's Commissioner into vulnerable babies in England*. London: Children's Commissioner.

Intergenerational trauma is described as the effect of accumulated, prolonged and unresolved trauma experienced by the same community over successive generations, though it may originate in a first-hand experience of collective trauma among only a subset of that community.^{56,57}

Intergenerational trauma can be used to refer to a combination of various behavioural and psychological conditions, including anxiety, depression, dissociation, fear, mistrust, posttraumatic stress disorder, self-harm, silence, substance use and violence.⁵⁸ Elements of intergenerational trauma from international and Australian research are shown in Figure 4.

Intergenerational trauma is a significant driver of vulnerability and involvement in child and family services. Evidence shows that trauma-informed approaches in families and communities where intergenerational trauma and disadvantage exist are critical.⁵⁹

⁵⁶ Intergenerational trauma was first identified among Jewish populations who survived the Holocaust. It has since been identified among Aboriginal populations in Australia and North America, Rwanda, Cambodia and other populations that have experienced major traumatic events, such as colonisation, forced removal of children, genocide and war: Evans-Campbell T (2008). "Historical Trauma in American Indian/Native Alaskan Communities." *Journal of Interpersonal Violence* 23(3): 316-38.

⁵⁷ Ibid; Marsh TN. 2016. "Indigenous Healing and Seeking Safety: A Blended Implementation Project for Intergenerational Trauma and Substance Use Disorders." *The International Indigenous Policy Journal* 7(2); Van der Kolk B. 2006. "Develop Aboriginal and Indigenous Community Health". 4(2): 118-136.

⁵⁸ Mohat NV, et al. 2014. "Historical trauma as public narrative: A conceptual review of how history impacts present-day health," *Social Science and Medicine* 106: 128-36.

⁵⁹ Healing Foundation. 2015. *Growing our Children up Strong and Deadly: Healing for children and young people*. Canberra: Healing Foundation; Atkinson J, Nelson J & Atkinson C. 2010. "Trauma, transgenerational transfer and effects on community wellbeing." *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice*. Dudgeon P, Milroy H & Walker R (Eds). Canberra: Commonwealth of Australia: 135-44; Evans-Campbell T. 2008. "Historical Trauma in American Indian/Native Alaskan Communities." *Journal of Interpersonal Violence* 23(3): 316-38; Marsh TM, Coholic D, Cote-Meek S & Najavits LM. 2015. "Blending Aboriginal and Western healing methods to treat intergenerational trauma with substance use disorder in Aboriginal peoples who live in Northeastern Ontario, Canada." *Harm Reduction Journal* 12(14); Van der Kolk B (2006). "Develop Aboriginal and Indigenous Community Health". 4(2): 118-136; Brave Heart MYH, Chase J, Elkins J & Altschul DB. 2011. "Historical trauma among Indigenous peoples of the Americas: concepts, research and clinical considerations." *Journal of Psychoactive Drugs* 43(4): 282-90; Duran E & Duran B. 1995. *Native American Postcolonial Psychology*. Albany: State University of New York Press. Sotero, MM. 2006. "A Conceptual Model of Historical Trauma: Implications for Public Health Practice and Research." *Journal of Health Disparities Research and Practice* 1(1): 93-108.

Figure 4 | Common elements of intergenerational trauma⁶⁰

	A complex and collective traumatic experience Intergenerational trauma results from a severe and often prolonged traumatic experience, imposed on a group of people who share common characteristics or experiences, such as Indigenous communities and refugees.
	Inherited across generations The effects of trauma are transmitted from one generation to the next across multiple generations, impacting on people who did not experience the original trauma first-hand.
	Unresolved trauma Intergenerational trauma often occurs because trauma is unresolved and there is no process of healing, so the effects of trauma are passed on to subsequent generations.
	Impacts on individuals, families, communities and societies Intergenerational trauma impacts on individuals and groups of people, and is often part of the collective and cultural memory of a community.
	Mental, physical, spiritual, social and other effects Intergenerational trauma impacts on mental and physical health, as well as the emotional and spiritual well being of individuals and communities. It can contribute to complex behavioural and social problems.
	A highly variable phenomena, not a discrete diagnosis Intergenerational trauma is not a defined medical condition but a phenomena that describes the complex impacts of traumatic events across multiple generations. The prevalence and severity of intergenerational trauma is highly variable, both within and across communities affected by trauma.
	Compounded by contemporary stressors Present day stressors experienced by individuals and communities, such as racism, systematic inequalities and socio-economic disadvantage can increase the likelihood and severity of intergenerational trauma.

A significant body of literature considers intergenerational trauma as it applies to the Aboriginal and Torres Strait Islander context. Traumatic experiences from colonisation, including violence and loss of land, language and culture, and harmful policies – most notably the forced removal of children – inflicted trauma on many Aboriginal and Torres Strait Islander people. In many cases, this has been passed on to subsequent generations.⁶¹

There is no data on the prevalence of trauma for Aboriginal and Torres Strait Islander children in Australia. However, *Bringing them Home* found that most Aboriginal and Torres Strait Islander families were affected by the stolen generations:

*"Nationally we can conclude with confidence that between one in three and one in ten Indigenous children were forcibly removed from their families and communities in the period from approximately 1910 until 1970... Most families have been affected, in one or more generations, by the forcible removal of one or more children."*⁶²

⁶⁰ Healing Foundation. 2015. Growing our Children up Strong and Deadly: Healing for children and young people. Canberra: Healing Foundation; Atkinson J, Nelson J & Atkinson C. 2010. "Trauma, transgenerational transfer and effects on community wellbeing." Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice. Dudgeon P, Milroy H & Walker R (Eds). Canberra: Commonwealth of Australia: 135-44; Evans-Campbell T. 2008. "Historical Trauma in American Indian/Native Alaskan Communities." *Journal of Interpersonal Violence* 23(3): 316-38; Marsh TM, Coholic D, Cote-Meek S & Najavits LM. 2015. "Blending Aboriginal and Western healing methods to treat intergenerational trauma with substance use disorder in Aboriginal peoples who live in Northeastern Ontario, Canada." *Harm Reduction Journal* 12(14); Van der Kolk B (2006). "Develop Aboriginal and Indigenous Community Health". 4(2): 118-136; Brave Heart MYH, Chase J, Elkins J & Altschul DB. 2011. "Historical trauma among Indigenous peoples of the Americas: concepts, research and clinical considerations." *Journal of Psychoactive Drugs* 43(4): 282-90; Duran E & Duran B. 1995. *Native American Postcolonial Psychology*. Albany: State University of New York Press. Sotero, MM. 2006. "A Conceptual Model of Historical Trauma: Implications for Public Health Practice and Research." *Journal of Health Disparities Research and Practice* 1(1): 93-108.

⁶¹ Nous Group, 2018, Review of the evidence on intergenerational trauma and the implications for Aboriginal and Torres Strait Islander people. Prepared for The Healing Foundation.

⁶² Human Rights and Equal Opportunity Commission (HREOC). 1997. "Bringing them home – Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families. Canberra: Commonwealth of Australia.

While not everyone affected by the stolen generations experienced trauma, many did. Research shows that subsequent generations often displayed symptoms of trauma.⁶³ This is supported by recent findings about epigenetic nature of trauma (the changes in the function of genes), which show that maternal experiences prior to and during pregnancy can lead to changes in biological and behavioural phenotypes in their children. An emerging body of evidence suggests that paternal experiences can also contribute to epigenetic changes. Studies of populations affected by traumatic events (for example, survivors of the Holocaust, war and food crises) have shown that children of parents who experienced trauma often have epigenetic changes that can lead to developmental delays and symptoms of trauma in subsequent generations.⁶⁴

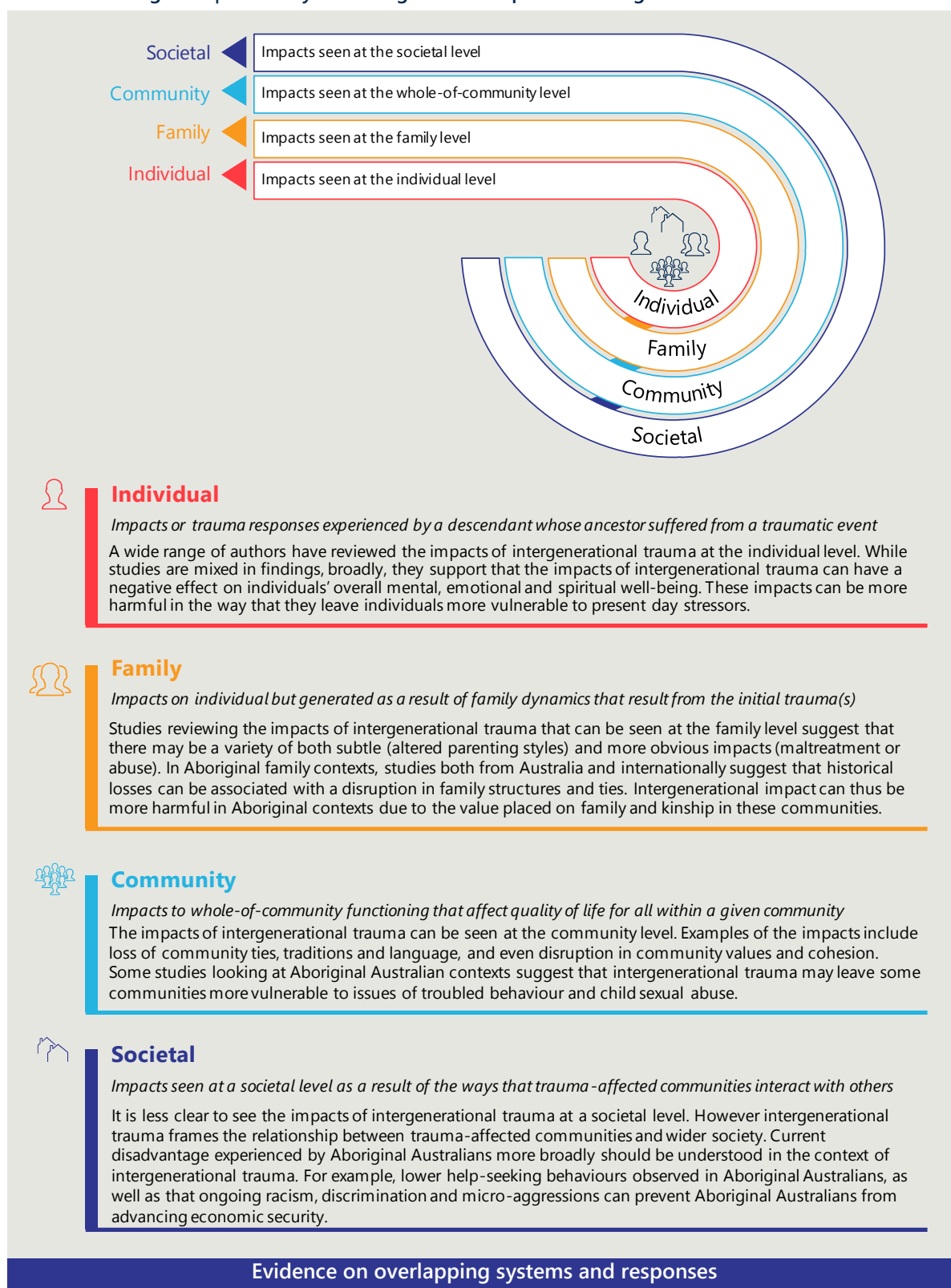
The evidence on the diverse, cumulative and long-lasting impacts of intergenerational trauma finds that people from the same community or family can display different symptoms despite sharing similar experiences. Accumulated experiences of trauma that are untreated and accompanied by stressors such as family violence, poverty and racism can increase the impact of intergenerational trauma.

While there is no uniform experience, there are several common ways in which intergenerational trauma impacts on individuals, families, communities and society (Figure 5).

⁶³ Ibid; Healing Foundation, 2017, *Cost Benefit Analysis of the Murri School Healing Program*. Canberra: Healing Foundation.

⁶⁴ Horsthemke B. 2018. A critical view on transgenerational epigenetic inheritance in humans. *Nature Communications*. 9(2973). Bowers M E, Yehuda R. 2018. Intergenerational Transfer of Biological Responses to Trauma: Impact of Psychosocial Stress in Fathers on Offspring. *Development and Environment* pp 421-433.

Figure 5 | Summary of findings on the impacts of intergenerational trauma⁶⁵



⁶⁵ Healing Foundation. 2015. Growing our Children up Strong and Deadly: Healing for children and young people. Canberra: Healing Foundation; Atkinson J, Nelson J & Atkinson C. 2010. "Trauma, transgenerational transfer and effects on community wellbeing." Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice. Dudgeon P, Milroy H & Walker R (Eds). Canberra: Commonwealth of Australia: 135-44; Evans-Campbell T. 2008. "Historical Trauma in American Indian/Native Alaskan Communities." *Journal of Interpersonal*

What works to respond to intergenerational trauma?

There is a growing body of evidence and practice on approaches to address intergenerational trauma:

- Trauma-specific care seeks to promote individual healing but can be applied to the individual, family and community levels. A range of therapies have been shown to be effective, including cognitive based therapies; phased treatment; neuroscience-informed approaches; collective therapies; therapies and ceremonies to promote healing at the community level; and blended therapies (for example, with drug rehabilitation therapies). Culturally competent practitioners help to ensure cultural safety.^{66 67}
- Trauma-informed services seek to build an awareness of trauma and its impacts into service design.⁶⁸ This includes policies and procedures through which organisations minimise the chances that receiving care will re-traumatise clients, as well as whole-of-organisation features such as organisational cultural competence, shared power and decision-making with clients and ensuring the self-determination, needs and preferences of clients and their communities are incorporated into service design and delivery.⁶⁹

Approaches can be targeted at the individual, family and community level. Community-wide approaches are most common for Aboriginal communities as they tend to promote connection to culture and participation in rituals that address unexpressed, compounded grief, as well as strategies that promote strong community functioning.⁷⁰

While healing can be achieved through therapeutic approaches, whole-of-society responses that involve non-Aboriginal members of the community and society can be driven by the development of policies and national guidelines that direct good practice responses to complex trauma, and by initiatives that drive change in the national attitudes and behaviours that can perpetuate intergenerational trauma. Examples include reconciliation and associated initiatives such as National Sorry Day and Reconciliation Action Plans aim to help support the healing of Stolen Generations and Aboriginal and Torres Strait Islander communities. These help to facilitate the healing process for communities and enable those affected to return to physical, emotional, spiritual and cultural wellbeing.⁷¹

This has implications for all services that interact with vulnerable children and their families. Research is increasingly showing that to break the cycle of intergenerational disadvantage, service systems should be trauma informed and children, their families and their communities should receive specific therapeutic supports to address trauma.

Violence 23(3): 316-38; Van der Kolk B. 2014. *The Body Keeps the Score: Brain, Mind and Body in the Healing of Trauma*. Penguin, New York; Meies, P. 2006. "Intergenerational trauma and homeless Aboriginal men". *Canadian Review of Social Policy*, 58:1-24 Fast E & Collin-Vézina D. 2010. "Historical Trauma, Race-based Trauma and Resilience of Indigenous Peoples: A literature review." *First Peoples Child & Family Review* 5(1): 126-36.

⁶⁶ Nous Group, 2018, Review of the evidence on intergenerational trauma and the implications for Aboriginal and Torres Strait Islander people. Prepared for The Healing Foundation.

⁶⁷ Nelson et al., 2014, *Aboriginal Practitioners Offer Culturally Safe and Responsive CBT: Response to Commentaries*. Australian Psychologist 49: 22-7.

⁶⁸ Wall L, Higgins D, Hunter C, 2016, *Trauma-informed care in child/family welfare services*. Child Family Community Australia Information Exchange, Paper No 37.

⁶⁹ Atkinson J, 2013, *Trauma-informed services and trauma-specific care for Indigenous Australian children*. Closing the Gap Clearinghouse resource sheet (21). Melbourne: AIHW and AIFS.

⁷⁰ Behrendt, L, 2008., "Reconciliation after the Apology", The 4th Annual Marg Barry Memorial Lecture.

⁷¹ Reconciliation Australia, 2013, National Sorry Day: An important part of healing. Retrieved from: <https://www.reconciliation.org.au/national-sorry-day-an-important-part-of-healing/>

Evidence on overlapping systems and responses

Why is trauma-based care important in child and family systems?

Many children and families who interact with child and family services have been exposed to traumatic events. A study from the United Kingdom found that at least 25 per cent of children and adolescents in the community experience at least one traumatic event during their childhood or adolescence, including maltreatment, violence or abuse.⁷²

The proportion of clients in the child protection system who have experienced trauma is likely far higher than this. Children in care are more likely to have been exposed to multiple forms of traumatic experiences. In addition to the circumstances that led to not being able to live at home, they may experience further stress and trauma after entering care, such as uncertainty about the future and separation from their friends, family, community and culture.⁷³

The effects of traumatic experiences on wellbeing and health can be profound. A study that has been ongoing since 1995 linked trauma childhood events, such as abuse and neglect, with increased likelihood of risk behaviour, disease, depression, suicide attempts, alcoholism and drug abuse later in life.⁷⁴

A growing body of scientific literature indicates the child and family system and service providers should incorporate a trauma-informed approach to treat child stress and trauma. In these systems, an understanding of the causes and effects of traumatic experiences informs the structure of the system and the practices incorporated into service responses.⁷⁵

Trauma-informed services are particularly important for Aboriginal and Torres Strait Islander populations. Researchers have found that trauma-informed approaches to child and family services, healthcare, education and other services may lead to more effective outcomes among Aboriginal and Torres Strait Islander peoples. Trauma-informed services are particularly important for Aboriginal and Torres Strait Islander populations. Research by the Healing Foundation and others indicates that many Aboriginal and Torres Strait Islander people, families and communities are experiencing intergenerational trauma because of the stolen generations, violent experiences during colonisation, separation from land and culture and other traumatic events. This trauma is often unresolved and negatively impacts on the psychological, physical, emotional and social wellbeing of individuals, families and communities (see further discussion on intergenerational trauma on page 22 above). This has important implications for service providers. Researchers have found that trauma-informed approaches to child and family services, healthcare, education and other services may lead to more effective outcomes among Aboriginal and Torres Strait Islander peoples.⁷⁶

A service system that embeds a comprehensive trauma-informed approach includes:

- awareness raising about trauma symptoms and services amongst families, practitioners and communities
- routine screening of children and families for trauma
- evidence-informed, culturally responsive practices to assess and treat traumatic stress and symptoms
- resource provision to children, families and practitioners on trauma exposure, its impact and available services
- continuity of care to reduce the risk of re-traumatising people
- maintenance of working environments that minimise and treat secondary traumatic stress in staff.⁷⁷

Trauma-informed care redirects attention from treating trauma *symptoms*, such as behavioural problems and physical or mental health issues, to treating the underlying *causes* of trauma.⁷⁸ With appropriate, trauma-informed supports, there is evidence that children and families can draw on their capacity for resilience and overcome the negative effects of trauma.⁷⁹

⁷²Costello E, Erkanli A, Fiarbank J and Angold A, 2002, The prevalence of potentially traumatic events in childhood and adolescence, *Journal of Traumatic Stress*, 15, 99-112.

⁷³Lain E, White A, 2013, *Implementing trauma-informed practices in child welfare*, ABA Center on Children and the Law.

⁷⁴Felitti VJ and Ruffolo R, Norderberg D, Williamson DF, Spitz AM, Edwards V and Marks JS, 1998, Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*, 14(4), 245-258

⁷⁵Lain E, White A, 2013, *Implementing trauma-informed practices in child welfare*, ABA Center on Children and the Law.

⁷⁶Atkinson J (2013). "Trauma-informed services and trauma-specific care for Indigenous Australian children". Closing the Gap Clearinghouse resource sheet (21), Melbourne: Australian Institute of Health and Welfare and Australian Institute of Family Studies; Healing Foundation. 2015. Growing our Children up Strong and Deadly: Healing for children and young people. Canberra: Healing Foundation; Atkinson J, Nelson J & Atkinson C. 2010. "Trauma, transgenerational transfer and effects on community wellbeing." Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice.

⁷⁷Ko S, Kassam-Adams N, Wilson C, Ford J, Berkowitz S and Wong M, 2008, *Creating trauma informed systems: child welfare, education, first responders, health care and juvenile justice*. Professional Psychology: Research and Practice, 29 (4), 396-404. Ko S and Sprague C, 2007, Creating trauma-informed child serving systems, NCTSN Service System Briefs, Los Angeles: National Centre for Child Traumatic Stress. National Child Traumatic Stress Network, n.d., *Creating Trauma-informed systems*. Retrieved from: <https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems>

⁷⁸Complex Trauma and Mental Health in Children and Adolescents, supra note 13.

⁷⁹Lain E, White A, 2013, *Implementing trauma-informed practices in child welfare*, ABA Center on Children and the Law.

Entrenched disadvantage

Breaking the cycle of entrenched disadvantage can reduce harm, provide appropriate and effective support and decrease the cost of and demand on services, particularly statutory services.⁸⁰ Disadvantage is defined as 'a range of difficulties that block life opportunities and which prevent people from participating fully in society.'⁸¹ Disadvantage is multifaceted. It is generally broader than economic poverty alone – it encompasses multiple layers of social exclusion and relative deprivation that restrict a person's participation in economic, societal and community spheres.⁸²

For children, disadvantage impacts how they live, learn and develop, which can lead to developmental delays and negatively impact on their health, education and wellbeing. Children experience poorer health and developmental outcomes with continually higher levels of disadvantage due to differences in social, demographic or economic circumstances. These outcomes represent inequities that are unjust, unnecessary and preventable.⁸³

Disadvantage can negatively impact on a child's development and outcomes.⁸⁴ Without a proactive approach to cognitive and social school development through investments in quality early childhood interventions, there will be several impacts.⁸⁵



Developmental outcomes. Children in poverty and with overlapping disadvantage are more likely to experience serious developmental delays which impacts on their school performance, long-term health, education, employment outcomes and overall wellbeing.⁸⁶



Decreased education attainment and adult earnings. Children who experience disadvantage tend to attain lower levels of education and may have decreased earning potential as an adult.⁸⁷



Intergenerational impacts for children and families. Disadvantage tends to be intergenerational, with children from disadvantaged families more likely to experience disadvantage through their lifetime and more likely to have children who also experience disadvantage.⁸⁸



Costly service delivery for government. Gaps in knowledge and ability between disadvantaged children and more advantaged peers appear long before kindergarten age and tend to persist through life. These gaps are difficult, service-intensive and costly to close.⁸⁹

⁸⁰ Healing Foundation. 2015. Growing our Children up Strong and Deadly: Healing for children and young people. Canberra: Healing Foundation; Atkinson J, Nelson J & Atkinson C. 2010. "Trauma, transgenerational transfer and effects on community wellbeing." Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice. Dudgeon P, Milroy H & Walker R (Eds). Canberra: Commonwealth of Australia: 135-44.

⁸¹ Vinson, T, 2007, Dropping off the edge: The distribution of disadvantage in Australia. Melbourne: Jesuit Social Services.

⁸² McDonald M, 2010. Are disadvantaged families "hard to reach"? Engaging disadvantaged families in child and family services. CAFCA Practice Sheet— September 2010. AIFS. Retrieved from: <https://aifs.gov.au/cfca/publications/are-disadvantaged-families-hard-reach-engaging-disadv>.

⁸³ Goldfeld S, O'Connor M, Chong S, Gray S, O'Connor E, Woolfenden S, Redmond G, et al, 2018, *The impact of multidimensional disadvantage over childhood on developmental outcomes in Australia*, International Journal of Epidemiology, 47, 5, 1485-1496.

⁸⁴ McDonald M, 2010. Are disadvantaged families "hard to reach"? Engaging disadvantaged families in child and family services. CAFCA Practice Sheet— September 2010. AIFS. Retrieved from: <https://aifs.gov.au/cfca/publications/are-disadvantaged-families-hard-reach-engaging-disadv>.

⁸⁵ Heckman J, 2017, 4 big benefits of investing in early childhood development. Retrieved at: <https://heckmanequation.org/resource/4-big-benefits-of-investing-in-early-childhood-development/> Heckman J, n.d., The Jamaican Study. Retrieved at: <https://heckmanequation.org/resource/the-jamaican-study/>

⁸⁶ McDonald M, 2010. Are disadvantaged families "hard to reach"? Engaging disadvantaged families in child and family services. CAFCA Practice Sheet— September 2010. AIFS. Retrieved from: <https://aifs.gov.au/cfca/publications/are-disadvantaged-families-hard-reach-engaging-disadv>.

⁸⁷ Heckman J, n.d., The Jamaican Study. Retrieved at: <https://heckmanequation.org/resource/the-jamaican-study/>

⁸⁸ McDonald M, 2010. Are disadvantaged families "hard to reach"? Engaging disadvantaged families in child and family services. CAFCA Practice Sheet— September 2010. AIFS. Retrieved from: <https://aifs.gov.au/cfca/publications/are-disadvantaged-families-hard-reach-engaging-disadv>.

⁸⁹ Heckman J, 2017, 4 big benefits of investing in early childhood development. Retrieved at: <https://heckmanequation.org/resource/4-big-benefits-of-investing-in-early-childhood-development/>

The capacity to change developmental trajectories declines with age (discussed further in section 2.3). Studies show that early developmental disadvantages persist into adult economic disadvantage and are often passed on to future generations.⁹⁰ For example, almost one-third of children and young people involved with the NSW statutory child protection system in 2014–15 had at least one parent who had either been reported or were in out-of-home care (OOHC) when they were a child.⁹¹ The intergenerational link was strongest for children and young people in OOHC, with almost 50 per cent having a parent who had either been reported or were in OOHC when they were a child.⁹²

Failure to redress early inequities creates increasingly wide gaps in rates of mortality and physical, social and cognitive impairments in adulthood. Despite this need for additional support, the many systems do not make it easy for disadvantaged families to engage, due to:

- the location of the service (for example, for families in remote areas or without access to transport)⁹³
- the service being perceived as intimidating due to past negative experiences⁹⁴
- lack of knowledge about what services are available, eligibility to access services or the importance of services to support healthy childhood development and family functioning.⁹⁵

Evidence on overlapping systems and responses

How to respond to disadvantage

Breaking the cycle of disadvantage is difficult. The AIFS recommends ‘flexible, multi-faceted and ongoing’ strategies and outline strategies for child and family services to engage with disadvantage services:

- Go to where the families are, such as local shopping centres, parks, employers and child care facilities.
- Promote and deliver services in a non-stigmatising and non-threatening way, including use of culturally competent practitioners and culturally appropriate services, particularly for Aboriginal and culturally and linguistically diverse communities.
- Employ strategies that empower families, including involving them in problem solving rather than creating a relationship of dependency
- Develop relationships, including with families that are non-judgemental, respectful, encouraging, empowering, authentic, empathetic and warm – as well as relationships with communities and other services.⁹⁶

Other pivotal frameworks and strategies that include actions to break the cycle of disadvantage include:

- The *National Early Childhood Development Strategy*, which seeks to address child development concerns early to reduce the likelihood of problems becoming entrenched. It led to investment in high-quality preschool education. The strategy draws on evidence that links children’s participation in high-quality early years education to better social, education, economic and health outcomes.
- The early intervention philosophy that underpins NSW Health’s *The First 2000 Days Framework*. This framework outlines a health system-wide approach to strengthen outcomes for children and families in the first 2000 days of a child’s life – a critical period for ensuring positive development and wellbeing outcomes that in turn help to break the cycle of disadvantage.

⁹⁰ Moore et al., 2017, *The First Thousand Days: An Evidence Paper*. Parkville, Victoria: Centre for Community Child Health.

⁹¹ FACS. 2017. The prevalence of intergenerational links in child protection and out-of-home care in NSW. Retrieved from: https://www.facs.nsw.gov.au/_data/assets/pdf_file/0016/421531/FACS_SAR.pdf.

⁹² Ibid.

⁹³ McDonald M, 2010, *Are disadvantaged families “hard to reach”? Engaging disadvantaged families in child and family services*. CAFCA Practice Sheet— September 2010. AIFS. Retrieved from: <https://aifs.gov.au/cfca/publications/are-disadvantaged-families-hard-reach-engaging-disadva>.

⁹⁴ Ibid.

⁹⁵ Carbone S, Fraser A, Ramburuth R and Nelms, L, 2004, *Breaking Cycles, Building Futures: Promoting inclusion of vulnerable families in antenatal and universal early childhood services. A report on the first three stages of the project*. Melbourne: Brotherhood of St Laurence.

⁹⁶ McDonald M, 2010, *Are disadvantaged families “hard to reach”? Engaging disadvantaged families in child and family services*. CAFCA Practice Sheet— September 2010. AIFS. Retrieved from: <https://aifs.gov.au/cfca/publications/are-disadvantaged-families-hard-reach-engaging-disadva>.

Evidence also shows that the earlier the investment in a child's life, the greater the return on investment over time in terms of human capital. It also shows that development gains are most significant for children from disadvantaged families.⁹⁷

2.3 Early childhood outcomes

Early childhood is a critical period and has lifelong impacts on health, cognitive, educational and employment outcomes. Achieving 'equity from the start' requires an understanding of points in a child's life where change can occur – this includes the first 2000 days of life, a significant and modifiable point for change, particularly the first 1000 days of life which is a period of **maximum brain development plasticity** and has the greatest impact on health, developmental and wellbeing outcomes over a person's lifetime.^{98,99}

Positive exposures and experiences of a developing foetus and child aged zero to five years has a profound impact across their lifetime, including on physical and psychological health, cognition, education and employment. Conversely, negative experiences during this period can lead to long-term disadvantage in these areas.¹⁰⁰

Multiple studies show that adverse experiences also have a cumulative impact on a child's development and health.¹⁰¹ For example, cumulative exposure to chronic stress can result in physiological changes to the body with long-term adverse impacts.¹⁰² Learning and development are cumulative processes, which means that each moment of learning for an infant or child impacts their future learning and development. This results in cumulative advantage or disadvantage and this gap increases over time without intervention.¹⁰³

There is evidence that poor health in infancy can be biologically transmitted across generations. Table 3 shows the variety of biological, environmental, social and individual factors on developmental outcomes in the first 2000 days.

The Access System Redesign must consider early childhood developmental factors when identifying clients and service responses, noting the diversity of factors and individual nature of families.

⁹⁷ Heckman J, 2017, 4 big benefits of investing in early childhood development. Retrieved at: <https://heckmanequation.org/resource/4-big-benefits-of-investing-in-early-childhood-development/>

⁹⁸ Moore et al., 2017, *The First Thousand Days: An Evidence Paper*. Parkville, Victoria: Centre for Community Child Health.

⁹⁹ Developmental plasticity is a biological process that allows humans to adapt to different social and physical environments. Neuroplasticity is a type of developmental plasticity that refers to 'the biological capacity of the central nervous system to change structurally and functionally in response to experience and adapt to the environment.' Neuroplasticity is strongest during pre- and postnatal brain development but is also strong in other stages of childhood: Moore et al., 2017, *The First Thousand Days: An Evidence Paper*. Parkville, Victoria: Centre for Community Child Health.

¹⁰⁰ Moore et al., 2017, *The First Thousand Days: An Evidence Paper*. Parkville, Victoria: Centre for Community Child Health.

¹⁰¹ Nous Group, 2018, Review of the evidence on intergenerational trauma and the implications for Aboriginal and Torres Strait Islander people. Prepared for The Healing Foundation.

¹⁰² Evans, G. W., & Schamberg, M. A. 2009. Childhood poverty, chronic stress and adult working memory. *Proceedings of the National Academy of Sciences*, 106 (16), 6545–6549; Seeman, T., Epel, E., Gruenewald, T., Karlamangla, A., & McEwen, B. S.

2010. Socio-economic differentials in peripheral biology: Cumulative allostatic load. *Annals of the New York Academy of Sciences*, 1186, 223–239.

¹⁰³ Morgan P. L., Farkas G. and Hibel J. 2008. Matthew effects for whom? *Learning Disability Quarterly*, 31(4): 187–198.

Table 3 | Factors that impact a child's development in the first 2000 days of life^{104 105}

Individual	<p>Factors: poor maternal and infant nutrition; maternal tobacco, alcohol and illicit drug use; lack of breast feeding in the first six months; and significant stress.</p> <p>Potential impacts: cognitive, neurological, physical, behavioural and emotional impairments.</p>
Biological	<p>Factors: poor maternal and infant nutrition, severe stress, trauma, abuse and neglect.</p> <p>Potential impacts: changes in the function of genes (known as 'epigenetic effects') and in brain synaptic connections in and between areas of the brain that are responsible for cognitive, social and emotional development. This can have long-term effects on a child's organs (including brain development), tissues, cognitive functioning, behaviours and health and wellbeing. Epigenetic changes due to early childhood trauma can be transmitted across generations.</p>
Environmental	<p>Factors: exposure to toxins (for example, chemicals and pollution in the air, water and food)</p> <p>Potential impacts: birth defects, neurological, cognitive and other health conditions, poor microbe health, increased likelihood of developing a non-communicable disease later in life, including obesity and cardiovascular disease.</p>
Social determinants of health	<p>Factors: Poverty, homelessness, poor parenting, trauma, abuse and neglect.</p> <p>Potential impacts: diminished caregiver's capacity to look after their children; long-term disadvantage; inadequate access to food, housing, clothing, healthcare and other essential items; and negatively impacted brain and hormonal systems for children, with lifelong outcomes.</p>

¹⁰⁴ Moore et al., 2017, *The First Thousand Days: An Evidence Paper*. Parkville, Victoria: Centre for Community Child Health.

¹⁰⁵ Evans, G. W., & Schamberg, M. A. 2009. Childhood poverty, chronic stress and adult working memory. *Proceedings of the National Academy of Sciences*, 106 (16), 6545-6549; Seeman, T., Epel, E., Gruenewald, T., Karlamangla, A., & McEwen, B. S. 2010. Socio-economic differentials in peripheral biology: Cumulative allostatic load. *Annals of the New York Academy of Sciences*, 1186, 223-239.

Leveraging the evidence on what works for Aboriginal families and communities



This evidence review identifies available evidence on good practice and what works for vulnerable Aboriginal children, families and communities is an important requirement of this evidence review. Aboriginal people and communities have experiences of the child and family services access system that are influenced by the legacy of forced removals and the Stolen Generations and institutionalised racism and may prefer to interact with Aboriginal-focused services than directly with state-provided universal services.

Disadvantage in Aboriginal families and communities

Despite multiple reviews and reforms, evidence shows that the current NSW child and family system is not optimising wellbeing and safety for Aboriginal families and communities, who continue to be overrepresented across the continuum of care, particularly in child protection and OOHC responses. This can be attributed to the legacy of past practices, inter-generational trauma, family and cultural disconnection, structural inequality and cultural differences in child rearing practices.¹⁰⁶

For Aboriginal children, the situation is more complex than for non-Aboriginal children. Aboriginal communities are more likely to experience disadvantage in terms of housing, education, employment and other areas. However, these social determinants do not capture other factors, such as kinship, cultural traditions and connection to traditional lands.

Conversely, colonisation, the stolen generations and other traumatic experiences have broken down these cultural norms and traditions for many communities, which has had a major impact on the health and wellbeing of children, families and communities.

Aboriginal family and knowledge systems of caring for children are among the most significant aspects of Aboriginal culture and is critical to a child's physical, emotional, social, cognitive, cultural and spiritual development.

The connections to family, community, Country and culture are central to a child's lifelong wellbeing, identity and sense of belonging. Aboriginal culture is rich, strong and diverse despite the profound impacts of colonisation including the forced removal of Aboriginal children from their families.

The effects of intergenerational trauma, cultural disconnection and family disruption continue to be lived and experienced by Aboriginal people today emphasising the critical need for healing and empowering Aboriginal people through their own processes.¹⁰⁷

¹⁰⁶ Ibid.

¹⁰⁷ Absec, n.d., Aboriginal Case Management Policy: Strengthening Aboriginal families, delivering outcomes for Aboriginal children and young people. Unpublished.

Early childhood is a significant, modifiable point of change. Peer-reviewed evidence from Australia and overseas demonstrates that effective early childhood programs can influence people's long-term health, cognitive, developmental and wellbeing outcomes. In the context of the Access System Redesign, this evidence provides a compelling case for investment in evidence-based, high-quality early childhood interventions to address risk factors and improve child development outcomes.

For example:

- A systematic review of the later impacts of early childhood interventions found they can, but do not always, lead to **benefits later in life in the areas of cognition, language, socio-emotional health, education and the labour market**. The review further found that interventions lasting at least the full 2000 days were most effective.¹⁰⁸
- A review of 30 early childhood interventions in 23 countries found that children received **substantial cognitive, behavioural, health and schooling benefits** from early childhood interventions, which were sustained over time. Educational interventions have the largest cognitive effects.¹⁰⁹
- Studies by Nobel Laureate and economist James Heckman and colleagues have found that investment in early childhood is more effective and efficient than investing in human capital later in life. Heckman's research has shown that early childhood interventions can:
 - **prevent knowledge and ability gaps** between disadvantaged children and their more advantaged peers, including in terms of school and employment outcomes, with this gap easier to prevent in early childhood than later years of childhood and adulthood¹¹⁰
 - **improve health outcomes**, with a United States study finding that more than 30 years later, a group of disadvantage children involved in interventions that incorporated education, nutrition and health from birth to age five were at significantly lower risk of cardiovascular and metabolic diseases, such as stroke and diabetes than their peers¹¹¹
 - **boost earnings**, with a study in Jamaica finding that disadvantaged children involved in an early education programs from 9 to 24 months earned 25 per cent more than their peers and that 98 per cent were employed at age 22¹¹²
 - **offer a strong of investment**, with the rate of return on investments in quality childhood development for disadvantaged children in the US estimated to be 7 to 10 per cent per annum through better outcomes in education, health, sociability, economic productivity and reduced crime.¹¹³

The Heckman curve shows that investments in the prenatal and infancy periods have the greatest economic return for investments in human capital (see Figure 6). In terms of reducing both the demand on services and the overall cost of service provision for the NSW population, this evidence further builds the case for effective and universal early childhood programs in the Access System Redesign.

¹⁰⁸ Tanner J C, Candland T, Odden W S. 2015. Independent Evaluation Group. *Later Impacts of Early Childhood Interventions: A Systematic Review*. The World Bank. Washington: DC. Retrieved from:

http://ieg.worldbankgroup.org/sites/default/files/Data/Evaluation/files/ImpactsofInterventions_EarlyChildhoodonLaterOutcomes.pdf.

¹⁰⁹ Nores M and Barnett S W. 2010. 'Benefits of early childhood interventions across the world: (Under) Investing in the very young. *Economics of Education Review*. 29 (2), pp271-282.

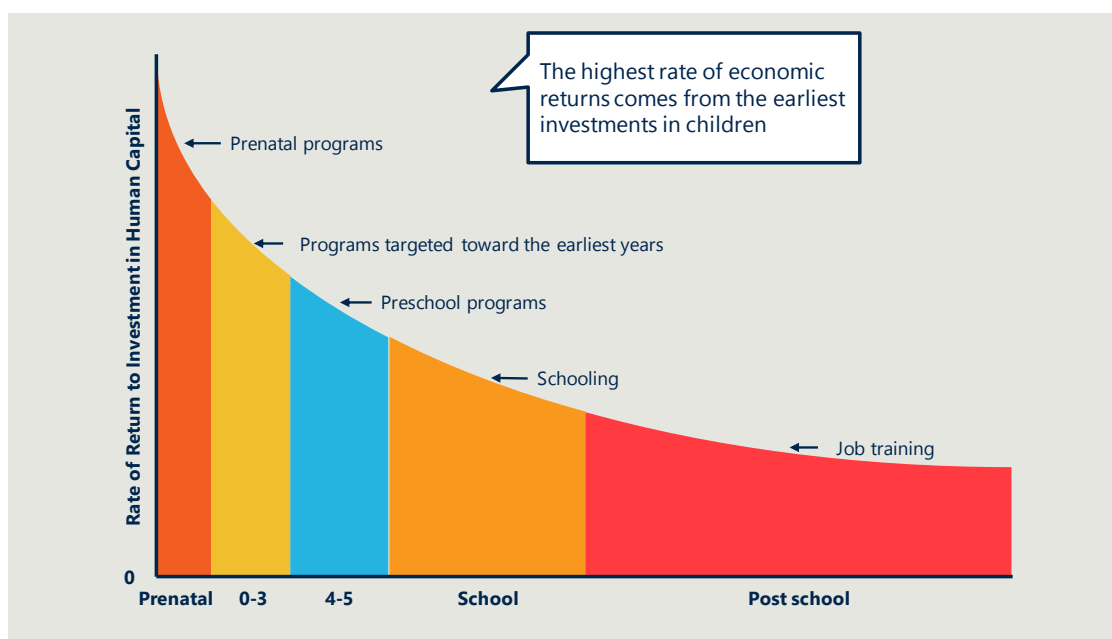
¹¹⁰ Heckman H J. 2017. *Four Big Benefits of Investing in Early Childhood Development*. The Heckman Equation. Retrieved from: https://heckmanequation.org/assets/2017/01/F_Heckman_FourBenefitsInvestingECDevelopment_022615.pdf.

¹¹¹ Campbell, Frances, Gabriella Conti, James J. Heckman, Seong Hyeok Moon, Rodrigo Pinto, Liz Pungello and Yi Pan. "Early Childhood Investments Substantially Boost Adult Health." *Science* 343 (2014): 1478-1485.

¹¹² Gertler, Paul, James Heckman, Rodrigo Pinto, Arianna Zanolini, Christel Vermeersch, Susan Walker, Susan M. Chang, Sally GranthamMcGregor. "Labor market returns to an early childhood stimulation intervention in Jamaica." *Science* 344.6187 (2014): 998-1001.

¹¹³ Heckman H J. 2017. *Four Big Benefits of Investing in Early Childhood Development*. The Heckman Equation. Retrieved from: https://heckmanequation.org/assets/2017/01/F_Heckman_FourBenefitsInvestingECDevelopment_022615.pdf.

Figure 6 | The Heckman Curve¹¹⁴



While adverse experiences in the first 2000 days greatly increase the risk of poor outcomes, this risk does not always manifest.¹¹⁵ **There is some evidence on factors that help to mitigate the effects of adverse childhood experiences, such as evidence-based post-first 2000 days interventions.**

For the Access System Redesign, this means that while the identification, assessment and response for children and families during early childhood are important, so are programs that target vulnerable sub-populations who may have had adverse experiences.¹¹⁶ For example:

- strengths and assets (for example, kinship, cultural connections) can minimise or overcome the negative impact of adverse experiences in the first 2000 days
- interventions post-2000 days can overcome physical and psychological harm to developmental outcomes caused by adverse experiences in the first 2000 days – for example, it is possible to unwind biological changes such as changes in epigenetic effects and synaptic connections in the brain
- interventions in post-2000 days generally need to be more intensive and longer term than pre-2000 days interventions to achieve the outcomes.¹¹⁷

2.4 What people need from a child and family system

The evidence suggests that segmenting different groups allows for a common understanding of the general and specific needs of children and families, so services and resources can be more effectively targeted to these needs.¹¹⁸ Segmentation also helps to estimate the volume of users based on their level of vulnerability.

¹¹⁴ Heckman J J. *The Heckman Curve*. Retrieved from <https://heckmanequation.org/resource/the-heckman-curve/>

¹¹⁵ Moore et al., 2017, *The First Thousand Days: An Evidence Paper*. Parkville, Victoria: Centre for Community Child Health.

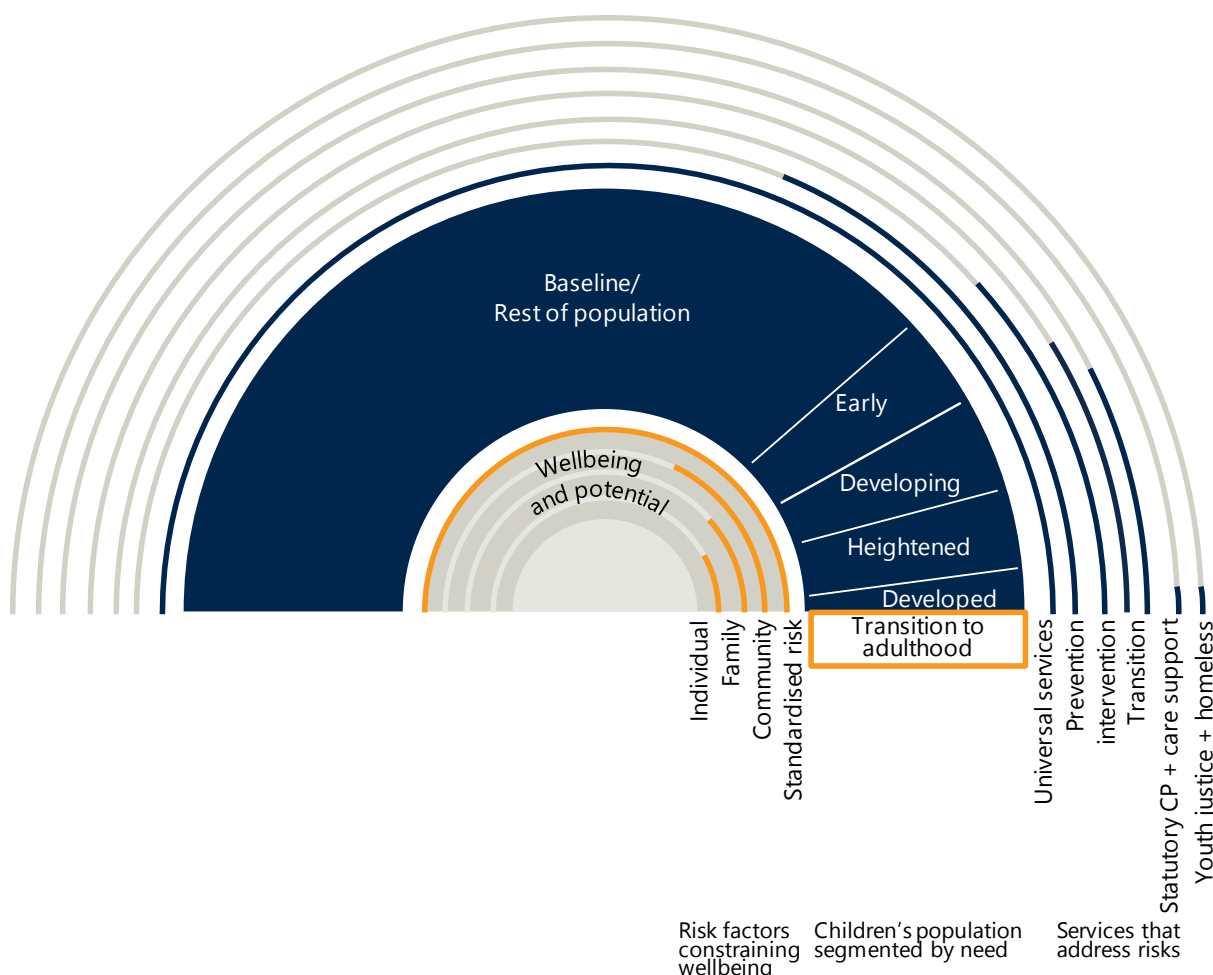
¹¹⁶ Britto P R, 2017, *Early Moments Matter for every child*. UNICEF, New York. Retrieved from https://www.unicef.org/publications/files/UNICEF_Early_Moments_Matter_for_Every_Child.pdf.

¹¹⁷ Moore et al., 2017, *The First Thousand Days: An Evidence Paper*. Parkville, Victoria: Centre for Community Child Health.

¹¹⁸ Kossarova, Devakumar D, Edwards N. 2016. The future of child health services: new models of care. Nuffield Trust. Retrieved from: <https://www.nuffieldtrust.org/files/2017-01/future-of-child-health-services-web-final.pdf>.

Our early research and analysis identified a potential future approach that categorises groups into six cohorts based on their level of vulnerability (Figure 7). It does not consider how people may move through the system, but rather how they encountered services. Vulnerability is indicated by how many of types of services a child or family encountered.

Figure 7 | Proposed future segmentation of NSW user groups for the access system¹¹⁹



This work estimates that around 650,000 children and young people have some level of vulnerability (described below in terms of early to developed) and are likely to need some level of support from the child and family service system:

1. **Baseline or rest of population:** children who are not vulnerable, based on information available to government, though may still have an unreported or unmet demand (estimated at 1.1 million children and young people).
2. **Early:** children aged zero to five who show poor educational or health development (estimated at 195,000).
3. **Developing:** children in families with poor financial wellbeing, housing assistance, parents with significant health, social or educational difficulties or low life skills who therefore are at greater risk of developing vulnerability (estimated at 235,000).

¹¹⁹ Ernst and Young, 2016, *Access System Redesign – Preliminary User Segmentation*. Sydney: Ernst and Young.

4. **Heightened:** children in families exhibiting signs of heightened risk (estimated at 191,000), including:
 - a. children recently assessed at risk of significant harm (ROSH) but not currently in a placement
 - b. children living in concerning conditions that do not meet the statutory threshold but not receiving intervention such as families in which there is DFV, substance abuse, neglect, limited stability or resilience (for example, transience), a family member in corrections or early signs of impacts such as truancy or poor physical health.
 - c. children in families that are receiving intensive services
 - d. children who have been in OOHC previously but have now achieved permanency.
5. **Developed:** children who have experienced trauma, are likely to be at ROSH, exhibit behavioural problems or are homeless (estimated at 28,000 number of children and young people).
6. **Transition to adulthood:** young adults who have left OOHC or other form of family support, many of whom may struggle with education, employment or training.¹²⁰

Our analysis identified needs from the perspective of the system and service providers as opposed to needs identified by children, young people and families. This found that **meeting these diverse service needs requires services from multiple agencies.**

Table 4 shows the predicted service needs and proposed agencies responsible for meeting them. This will require the collaborative efforts of many agencies, including FACS and those involved in health, justice, education, housing and employment.

¹²⁰ Ernst and Young, 2016, *Access System Redesign – Preliminary User Segmentation*. Sydney: Ernst and Young. Note: These are not discrete categories, so the data does not add to 100 per cent.

Table 4 | Predicted needs of NSW access system users across proposed user segments

User segment	Predicted service needs of children and young people	Predicted needs of families	Responsible agencies
1. Baseline vulnerability	<ul style="list-style-type: none"> Universal services, including early access to high quality early education and healthcare 	<ul style="list-style-type: none"> Universal services, including healthcare access to address maternal and family health needs 	Health Education
	Universal services can make an early identification of children and young people that may require targeted services		
2. Early vulnerability	As above and: <ul style="list-style-type: none"> targeted support for developmental, physical and mental health needs targeted support to address development, learning and behavioural issues 	As above and: <ul style="list-style-type: none"> life skills development for families with young children 	Health Education
3. Developing vulnerability	As above and: <ul style="list-style-type: none"> support for those with a parent or family member in corrective services 	As above and: <ul style="list-style-type: none"> support for physical and mental health needs of household members skills development to support employment support to address financial stability issues access to affordable housing support for parents coming out of corrections 	Health Education Employment Housing Justice
4. Heightened vulnerability	As above and: <ul style="list-style-type: none"> interventions to keep children safe and well with their families physical and mental health needs social and development needs 	As above and: <ul style="list-style-type: none"> family violence and rehabilitation needs 	FACS Health Education Justice
5. Developed vulnerability	<ul style="list-style-type: none"> Provide care for children previously in unsafe environments Address physical and mental health needs Address social and development needs Provide transition services from juvenile justice 	<ul style="list-style-type: none"> Children and young adults no longer in care of family Promote family reunification if appropriate 	FACS Health Education Justice
6. Transition to adulthood	<ul style="list-style-type: none"> Access to affordable housing solutions Support for those coming out of corrections Address physical and mental health needs of young adults Skills development to support employment Address financial stability issues for young adults 	<ul style="list-style-type: none"> Young adults no longer in care of family, transitioning out of home care 	Health Education Employment Housing Justice

3 Overlap and similarities between child and family systems and other social service systems

Key insights

- It is impossible to isolate the child and family system from overlapping responses.
- Siloed responses do not recognise the common causes, multi-dimensional nature of risks and complexity of needs.
- Evidence shows that siloed responses to complex social issues are less effective than collaborative, multiagency responses.
- Preliminary analysis of some social service and health responses indicates significant overlap in client needs and some evidence on what works to respond, such as trauma informed practice.

Child protection and wellbeing responses overlap with other systems, such as those that support with individuals, families and communities who experience DFV, intergenerational trauma, drug and alcohol misuse, mental illness and violence, abuse and neglect.¹²¹ **It is impossible to isolate the child and family system from overlapping responses.**

Common underlying causes that necessitate people needing support and services to maintain safety and promote wellbeing include gender and other social inequalities, developmental inequality in the case of children and young people and dynamics of power and control.¹²² This leads to overlapping client bases, with families often accessing services for child protection or wellbeing, as well as for DFV, drug and alcohol and mental health.

Despite many of the same children and families accessing these services, a response that is contained within one agency or policy area – referred to as a siloed approach – **does not recognise the common causes, multi-dimensional nature of risks and complexity of needs.** No single agency can address these.

The evidence indicates that a siloed response means many clients have multiple touchpoints – services are delivered by different agencies, service delivery is uncoordinated, solutions are only partial and some high-need families fall between the cracks. An individual or members of the same family might have multiple interactions – for example, emergency room presentations, housing applications and encounters with police – which, as incident-based support, fails to build a picture of cumulative risk or recognise the holistic needs of the family.

Families can face a confusing network of entry points and may not understand the types of services and support available.¹²³ This can mean high-need individuals and families may not receive early intervention and support, as the service system does not pick up the intensity of their situation.

From the perspective of service providers and NSW government agencies, limited coordination is inefficient, with multiple working groups about similar issues with similar participants, and duplicates effort (for example, housing, DFV and child protection services may provide similar support in similar areas and/or to the same families).

¹²¹ “Violence, abuse and neglect” is used as an umbrella term for three types of interpersonal violence that are widespread in the Australian community. This includes all forms of child abuse and neglect, DFV and sexual assault. Based on the NSW Health definition.

¹²² NSW Health, n.d., *NSW Health responses to violence, abuse and neglect; promoting an integrated approach*. Unpublished, NSW Health.

¹²³ Women NSW, *Blueprint Consultation Report: Draft Cabinet in Confidence*, unpublished, Sydney, March 2016.

Evidence shows that siloed responses to complex social issues are less effective than collaborative, multiagency responses.¹²⁴ These responses cannot tackle significant, intractable problems as effectively as agencies that work in collaboration, especially for families with multiple and complex problems.¹²⁵ A coordinated multiagency response and cross-agency collaboration addresses the limitations of siloed responses.

Our analysis of social service and health responses indicates an overlap in client needs and some solutions, such as trauma informed practice. This analysis will inform efforts to better align and streamline service delivery and enabling functions through the Access System Redesign.

Table 5 highlights the social issues with common underlying causes and service responses, compared to the child and family system. While not a comprehensive review of all evidence for these overlapping responses, it indicates:

- People who interact with child protection and child and family services and services that respond to DFV, drug and alcohol misuse and mental health have common needs.
- While there is a varying level of evidence on what responses work in each of these systems, overall there is relatively strong evidence on some key responses or services.
- Trauma-informed practices and service provision are likely to be important across these systems due to the prevalence of trauma within child safety and wellbeing issues and the likelihood that navigating a complex service system and needing to repeat your story can cause trauma and stress to clients.
- Consideration of service systems that intersect with the child and family system have overlapping causes and client bases with child protection and wellbeing and this provides an opportunity to better coordinate and streamline service delivery.¹²⁶

¹²⁴ Valentine K and Hilferty F, 2012, *Why Don't Multi-Agency Child Welfare Initiatives Deliver? A Counterpoint to Best Practice Literature*. Social Policy Research Centre.

¹²⁵ AIFS, 2011, *Interagency collaboration: Part A. What is it, what does it look like, when is it needed and what supports it?* AIFS

¹²⁶ AIFS, 2011, *Interagency collaboration: Part A. What is it, what does it look like, when is it needed and what supports it?* AIFS

Table 5 | Overlapping service systems and policy and system implications

DFV	Violence, abuse and neglect	Intergenerational trauma
What are the needs of clients?		
<ul style="list-style-type: none"> Often require long-term, holistic support to empower families to transform their situations. Often require multiple services including housing, financial assistance, child protection services, disability services, health services, referral services, drug and alcohol services, case management, counselling and practical support. Require different options for entry points as people interact with the system differently depending on their identity, physical or intellectual capacity or culture.¹²⁷ 	<p>Service needs may include:</p> <ul style="list-style-type: none"> counselling family/caregiver programs housing or alternative living arrangements, including OOHC education for those at risk intensive service programs to maintain vulnerable families practical support such as financial assistance, transportation and casework health services such as mental health, child and maternal health and nutritional education.¹²⁸ 	<ul style="list-style-type: none"> Diverse symptoms and impacts, which means the needs of individuals varies. Needs can include mental, physical, emotional and spiritual needs, parenting support, violence prevention and community development. Community level needs can include the need for support to address the loss of language, culture, identity and customs.¹²⁹
What responses work?		
<ul style="list-style-type: none"> Services need to be coordinated; fragmented service delivery presents barriers for people accessing or maintaining contact with services. Assessments should involve global assessment of a client's development, history and functioning across different situations. 		
<ul style="list-style-type: none"> Adequate capacity to provide accommodation services at times of crisis is critical. Multiple risk assessment tools limit the ability of agencies to provide an early, coordinated response. The system should recognise the unique risk factors of at-risk cohorts to deliver client-centric, tailored services.¹³⁰ 	<ul style="list-style-type: none"> For children and young people, effective treatment should integrate with their day-to-day living as these day-to-day experiences with other people contribute to recovery and development.¹³¹ Differences in service and evaluation designs make it difficult to compare social service interventions. Examples for which there is varying evidence of effectiveness include: 	<ul style="list-style-type: none"> There are a range of approaches for working with whole communities to heal the trauma of past events through connection to culture and related rituals. Evidence indicates that strong communities are protective of individual social and emotional wellbeing. Approaches to working with people who experience intergenerational trauma can be divided into trauma-specific and trauma-informed care. Trauma-specific care

¹²⁷ Women NSW, *Blueprint Consultation Report: Draft Cabinet in Confidence*, unpublished, Sydney, March 2016; FACS, *NSW DFV Service Re-alignment Review: Phase 1 Report*, NSW Government, Sydney, 2014.

¹²⁸ Chalk R and King P, 1998, *Violence in families: access prevention and treatment programs. Chapter 4: social service interventions*. Washington: The National Academies Press.

¹²⁹ Nous Group, 2018, Review of the evidence on intergenerational trauma and the implications for Aboriginal and Torres Strait Islander people. Prepared for The Healing Foundation.

¹³⁰ Nous Group, 2016, DFV Service System Redesign work undertaken for Women NSW. Not published.

¹³¹ Lud-Dobson C and Perry B, 2010, *Working with children to heal interpersonal trauma: the power of play. Chapter 3: The Role of Healthy Relational Interactions in Buffering the Impact of Childhood Trauma*. The Guilford Press.

DFV	Violence, abuse and neglect	Intergenerational trauma
	<ul style="list-style-type: none"> individual social support interventions such as parenting programs) multiservice interventions that match services to the specific needs of families risk assessment interventions that assess the strength of the family support systems social skills training that seeks to improve a family's ability to gain access to appropriate resources and services intensive family preservation services.¹³² 	<p>seeks to promote individual healing but can be applied to the individual, family and community levels.</p> <ul style="list-style-type: none"> Interventions may focus on healing families, such as trauma-focused cognitive behaviour therapy, and healing communities, such as interventions focused on restoration, community resilience, and reconnection and community life. Whole-of-society policies and national guidelines are required to inform responses to complex trauma and initiatives and drive change in the national attitudes and behaviours that can perpetuate intergenerational trauma.¹³³

What are the policy and design implications?

- | | | |
|---|---|--|
| <ul style="list-style-type: none"> Adequate investment in prevention and early intervention is required to help address the causes of DFV. Service providers need the capability and capacity to respond to issues relating to DFV, but also issues concerning child protection and vulnerable families. The system should not be incident-based; it must recognise that DFV is cyclical and provide coordinated, sustained support, so that clients can avoid resetting their journey after each incident. This would help to reduce any instance of secondary trauma for victims. While flexibility is important, State-wide programs need consistency in service delivery quality. | <ul style="list-style-type: none"> The complexity of the prevalence, health impacts, causes and responses to violence, abuse and neglect necessitates a whole-of-health system response, along with other social service responses. Health and social services practitioners need to understand these issues and have the capability and capacity to respond to violence, abuse and neglect with support from the specialist services. Specialist violence, abuse and neglect services need integrated responses to all forms of violence, abuse and neglect and not solely respond to the issues for which they have primary responsibility. Prevention and intervention activities are needed at the individual, community and society level. | <ul style="list-style-type: none"> Care for people experiencing intergenerational trauma needs to take place at the individual, family and community levels. Determinants of intergenerational trauma are generated at a societal level and strategies for healing need to be aligned. Trauma-informed approaches seek to build awareness of trauma and its impacts into service design. Policies should maximise each organisations' ability to deliver an environment where clients are safe, staff understand the need to minimise triggers and services manage elements of delivery that may re-traumatise clients. |
|---|---|--|

¹³² The National Academies of Sciences, Engineering and Medicine, 1998, *Violence in Families: Assessing Prevention and Treatment Programs*. Chapter 4: Social Service Interventions. Retrieved at: <https://www.nap.edu/read/5285/chapter/6#97>

¹³³ Nous Group, 2018, Review of the evidence on intergenerational trauma and the implications for Aboriginal and Torres Strait Islander people. Prepared for The Healing Foundation.

Leveraging the evidence on what works for Aboriginal families and communities



Evidence shows that Aboriginal children, families and communities have better outcomes when Aboriginal people are involved in decisions about the design and delivery of services.

Research from Australia, New Zealand, Canada and other places emphasise the importance of involving Aboriginal people in service design and delivery. Deficiencies in traditional child protection systems in these countries have contributed to the overrepresentation of Aboriginal populations and reduced effectiveness of child and family services in many Aboriginal communities.¹³⁴

Lone and Harris (2018) conclude that: 'Service users, particularly Indigenous communities and community-controlled organisations, can play a vital role in ensuring that the results of system re-design lead to better outcomes for children and families.'¹³⁵

Community development and strengths-based approaches guide collaboration with Aboriginal communities to design and delivery services. They can help to reflect the strong connection to land and commitment to family and community in service planning and delivery, which can then reduce the likelihood of child safety issues as they:

- act as a protective factor to enable child and family wellbeing
- strengthen positive self-identity
- reduce the likelihood of substance abuse and contact with the criminal justice system
- positively contribute to physical safety, wellbeing, educational attainment and employment.^{136 137}

The evidence identifies four components of an Aboriginal-led service response that can better address the risks for vulnerable Aboriginal children and families and respond to intergenerational trauma and cycles of disadvantage. The evidence is supported by studies on services for Aboriginal people from Australia, New Zealand, Canada and other jurisdictions.¹³⁸ Implicit is involvement of Aboriginal organisations and people in the design and delivery of services.

- **Cultural safety:** this refers to the provision of appropriate interventions in a way that is respectful of a person's culture and beliefs and free from discrimination. Examples of culturally-safe practices include the use of ceremony as part of cultural engagement processes and collaborative group decision making and assessment processes.¹³⁹ Aboriginal children and families are more likely to engage with culturally safe services; they are also more likely to be effective because they are more likely to develop responses based on having listened to their clients.
- **Capacity building:** this refers to capacity building of existing Aboriginal community-controlled organisations being built into the broader service planning and response to support quality, continuous improvement and innovation.
- **Tiered approach to Aboriginal-led interventions:** this includes:
 - *A broad community response.* This is for the whole community and includes services such as education, universal health care and community engagement and development.
 - *Targeted interventions focused on Aboriginal family strengthening.* These target individuals and population groups that are at-risk (for example, facilitated access to peer support learning/parenting programs, broader support services like housing or family mediation).
 - *Aboriginal child safety response.* These are for families where abuse has occurred and include more intensive services like family preservation support and foster care/case management.
- **Aboriginal-specific service enablers:** this refers to relevant activities to strengthen system functions, such as governance and workforce, or recognising that child and family focused interventions alone cannot address broader issues and that other approaches such as community leadership, workforce development, community empowerment and development and education are important.¹⁴⁰

¹³⁴ Morley, S. (2015), 'What works in effective Indigenous community-managed programs and organisations', CFCA Paper No.32, Australian Institute of Family Studies; 2.Lohoar, S., Price-Robertson, R., & Nair, L. (2013) 'Applying community capacity-building approaches to child welfare practice and policy', CFCA Paper No.13, Australian Institute of Family Studies; 3.Lohoar, S. (2012), 'Safe and supportive Indigenous families and communities for children: A synopsis and critique of Australian research', CFCA Paper No. 7, Australian Institute of Family Studies.

¹³⁵ Ibid.

¹³⁶ ARTD Consultants, 2016, *Aboriginal consultation in child protection: research in the context of evolving understandings and practice*. ARTD.

¹³⁷ Morley, S. (2015), 'What works in effective Indigenous community-managed programs and organisations', CFCA Paper No.32, Australian Institute of Family Studies; 2.Lohoar, S., Price-Robertson, R., & Nair, L. (2013) 'Applying community capacity-building approaches to child welfare practice and policy', CFCA Paper No.13, Australian Institute of Family Studies; 3.Lohoar, S. (2012), 'Safe and supportive Indigenous families and communities for children: A synopsis and critique of Australian research', CFCA Paper No. 7, Australian Institute of Family Studies.

¹³⁸ Ibid.

¹³⁹ Ibid.

¹⁴⁰ AbSec, 2016, *Achieving a holistic Aboriginal Child and Family Service System for NSW*. Sydney: AbSec.

4 System structures

Key insights

- Typically, child and family systems in Australia and internationally are guided by a child protection-focused framework or a public health-based framework.
- A socio-ecological framework translates the public health approach to promote a social services system that focuses on care and wellbeing, rather than only responding to abuse and neglect.
- Under a socio-ecological framework, efforts can be targeted to individual, families, communities and societies, with a focus on prevention and early intervention.

Models of practice with the highest levels of evidence are:

- **Community hubs:** Evidence from approaches in many jurisdictions showed a single-entry point that is centrally coordinated but embedded locally within communities, staffed by multi-disciplinary local expertise, had benefits. Benefits included improved collaboration and improved wellbeing outcomes for children and families and reduced pressure on statutory services. Examples of effective community hub models are Aboriginal and Child Family Centres (NSW), Early Years Centres (QLD), The Orange Door (Victoria) and Children's Houses (Sweden). *Note: This evidence supports key system element 2: Community Hubs.*
- **Multi-disciplinary Teams:** Successful MDT models include the involvement of child protection and police services, cross-agency case planning, protocols and specialist infrastructure.¹⁴¹ Benefits included better coordination of services and joint accountability for better child outcomes. An example of a successful MDT in NSW is the JIRT program.¹⁴² *Note: This evidence supports key system element 3: Multi-agency service coordination.*
- **Family involvement in assessment:** Involvement of the family in assessment supports better outcomes and promotes family 'buy-in' to the process.¹⁴³ However, involving the family in the assessment process can be difficult as they can be involuntary participants and may be reluctant or unwilling to be involved.
- **Inclusion of the child:** Evidence shows that children and young people want and benefit from, greater engagement in their own service planning and delivery.¹⁴⁴ Embedding child inclusion in frameworks and policies, such as in the *Getting it Right for Every Child* Framework in Scotland or *Signs of Safety* in England, has resulted in greater child inclusion.¹⁴⁵ Ensuring case workers have the time to engage is important, for example, through having more caseworkers, increased efficiency or longer timeframes to engage.
- **Triage models and assessment tools:** Evidence is equivocal as to which triage models and assessment tools work best. There is no 'gold standard' tool or approach. A variety of tools are in use; most jurisdictions tools to the context. *Note: This evidence supports key system element 4: Common Assessment Framework.*

¹⁴¹ NSW Ombudsman, 2017, *The JIRT Partnership – 20 years on: NSW Ombudsman inquiry into the operation of the JIRT program*. Sydney; State of New South Wales.

¹⁴² NSW Ombudsman, 2017, *The JIRT Partnership – 20 years on: NSW Ombudsman inquiry into the operation of the JIRT program*. Sydney; State of New South Wales.

¹⁴³ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

¹⁴⁴ Bouma et al (2018)

¹⁴⁵ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

- **Lead professional:** NSW programs that have similar functions to a lead professional model include Family Referral Services (FRS), Early Links and Sustaining NSW Families. Models have diverse results including improved health, safety and developmental outcomes for children and families and improved access to services through coordination and education to clients about service availability.¹⁴⁶ Success factors include the personal skills and attributes of the person in the role, such as expertise in early childhood or child health. *Note: This evidence supports key system element 1: Lead professional as a separate intake point for sub-ROSH.*
- **Universal services:** Literature and best practice from Australia and overseas shows the importance of universal services (such as health and education) to support healthy early childhood development. For vulnerable populations, research indicates that: a) there may be a need for additional support to ensure people are accessing universal services; and b) universal services provide an opportunity to identify and refer vulnerable children and families and ensure to targeted services as appropriate.¹⁴⁷ Universal programs in the first 2000 days of life (zero to five years old) can prevent disease and disadvantage and promote positive outcomes for children. Research shows that the first 1000 days is particularly important as this is the period of maximum development plasticity and has the greatest impact on lifetime outcomes for a child.¹⁴⁸ Home visiting to new parents is one of the most popular interventions across jurisdictions, with evidence some programs can have a significant positive impact on children and mothers. Features of effective programs include skilled workers, a design that addresses the behavioural and psychosocial factors and targeting to high risk families.¹⁴⁹
- **Targeted services:** High-quality targeted early intervention can impact developmental outcomes and life trajectories. Successful programs in NSW include Brighter Futures, Early Links, FRS and Sustaining NSW Families.¹⁵⁰ Aboriginal-specific positions and involvement of Aboriginal Community Controlled Organisations can help to reach Aboriginal people and communities. Enablers of success for one model included soft entry points, a flexible approach depending on individual needs, strengths-based approach, community-driven and culturally appropriate design.¹⁵¹

Enabling components are:

- Success factors for **effective system governance** include collaboration across government and non-government stakeholders, clear governance structures and transparent reporting and dedicated resources to drive change.¹⁵² A single, whole-of-government planning framework can reduce duplication across the system and support multi-agency collaborative work to improve outcomes.¹⁵³
- Elements of a **best-practice funding and investment approach** included a whole-of-government outcomes framework to provide quantifiable measures to increase accountability and guide funding. It included structures that ensure cross-agency accountability in funding decisions and a reporting and reallocation cycle that continuously builds and uses the evidence base to inform funding decisions.¹⁵⁴
- There was limited evidence on **best-practice information and data collection and sharing approaches**. Key themes from reforms in other jurisdictions were investment in centralised

¹⁴⁶ TFM team summary based on research undertaken as part of the high-level design of the Access System.

¹⁴⁷ Centre for Community Child Health, 2017, *The first thousand days: an evidence paper*. Melbourne: Centre for Community Child Health.

¹⁴⁸ Centre for Community Child Health, 2017, *The first thousand days: an evidence paper*. Melbourne: Centre for Community Child Health.

¹⁴⁹ Olds DL and Kitzman H, 1990, *Can Home Visitation Improve the Health of Women and Children at Environmental Risk?* Journal of Paediatrics 86(1) 108-116.

¹⁵⁰ Cassells R et al., 2014, *Keep Them Safe Outcomes Evaluation Final Report*. Sydney: NSW Department of Premier and Cabinet.

¹⁵¹ ARTD Consultants, 2016, *Aboriginal consultation in child protection: Research in the context of evolving understandings and practice*. Unpublished.

¹⁵² Department of Health and Human Services, 2016, *Strong Families – Safe Kids: Implementation Plan 2016-2020*. Hobart: State of Tasmania.

¹⁵³ Ibid.

¹⁵⁴ Tune D, 2015, *The Tune Report: Independent review of OOHHC. Appendix 2*.

mechanisms to manage data and analytics and enabling legislation to support information sharing.¹⁵⁵

- Benefits of **technology-enabled child and family systems** included timely availability and retrieval of information, standardisation and protection of sensitive information and an incentive for increased accountability towards protecting children.¹⁵⁶ Successful development and implementation of new technologies needs to involve users, promote innovation and build in child-friendliness.¹⁵⁷
- Evidence shows a **sustainable, skilled workforce** needs ongoing training and professional development, promotion of a child protection profession and constructive workplace culture.¹⁵⁸ Improving the cultural competency of the workforce often requires Aboriginal workers, greater involvement of Aboriginal community-controlled organisations and greater cultural competency of the whole workforce through training and practice guidelines.¹⁵⁹
- Evidence suggests **effective system performance monitoring and evaluation** requires a logical framework with a clear chain of results and agreement on the required capacity for monitoring and evaluation programs (supported by funding).¹⁶⁰ Consistency with an agreed system-level outcomes framework is important to direct efforts and measure results across agencies and providers.¹⁶¹

4.1 System structures

Typically, child and family systems in Australia and internationally are guided by a child protection-focused framework that focuses on the statutory system versus a public health-based framework that focuses on prevention and early intervention.¹⁶²

Evidence shows that the focus of child and family systems in Australia and overseas is on child protection - identifying those at risk of harm and providing statutory child protection responses to ensure safety. They may have limited formal involvement across other service sectors

Examples of systems reorientating to focus on wellbeing and protection, as opposed to just protection

Scotland's **Getting It Right for Every Child** framework outlines a public health approach to improving outcomes and supporting the wellbeing of all CYP. It is used across agencies at the universal, secondary and tertiary service levels. It aims to ensure the right help is offered at the right time from the right people.

The **New Zealand (NZ) Ministry for Children** has a unifying philosophy of prevention. It guides investment in children's wellbeing and aims to reduce long-term costs to society.

¹⁵⁵ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

¹⁵⁶ Krauter C, 2017, *Child Protection Case Management*. Retrieved from <https://datanova.com.au/child-protection-case-management/>. Kaonga N, Batavia H, Philbrick W, Mechael P, 2016, *Information and Communication Technology for Child Protection Case Management in Emergencies: An Overview of the Existing Evidence Base*. Massachusetts; Procedia Engineering 159, 112-117, Smith R, Eaton T, 2014, *Information and Communication Technology in Child Welfare: The Need for Culture-Centered Computing*. Western Michigan; The Journal of Sociology & Social Welfare, 41(1).

¹⁵⁷ Krauter C, 2017, *Child Protection Case Management*. Retrieved from <https://datanova.com.au/child-protection-case-management/>. Kaonga N, Batavia H, Philbrick W, Mechael P, 2016, *Information and Communication Technology for Child Protection Case Management in Emergencies: An Overview of the Existing Evidence Base*. Massachusetts; Procedia Engineering 159, 112-117, Smith R, Eaton T, 2014, *Information and Communication Technology in Child Welfare: The Need for Culture-Centered Computing*. Western Michigan; The Journal of Sociology & Social Welfare, 41(1).

¹⁵⁸ Lewig K, McLean S, 2016, *Caring for our frontline child protection workforce*. s.l.; Child Family Community Australia. Baltruks D, Hussein S, Montero L, 2017, *Investing in the social services workforce*. Brighton; European Social Network. McArthur M, Thomson L, 2012, *National analysis of the workforce trends in statutory child protection*. Canberra; Institute of Child Protection Studies. Tune D, 2015, *The Tune Report: Independent review of OOHCC*.

¹⁵⁹ AbSec, 2016, *Achieving a holistic Aboriginal Child and Family Service System for NSW*. Sydney: AbSec. Department of Child Protection and Family Support, 2016, *Building Safe and strong Families: Earlier Intervention and Family Support Strategy*. s.l.; Government of Western Australia.

¹⁶⁰ Ibid.

¹⁶¹ Ernst and Young, 2016, *Access System Redesign – Preliminary User Segmentation*. Sydney: Ernst and Young.

¹⁶² AIHW, 2010, *Child protection Australia 2008-09*, Canberra, ACT: AIHW, referenced in Price-Robertson, R et al, 2014

or include involvement with the broader community sector to support child and family wellbeing.¹⁶³

Both the United Kingdom and United States have also focused on child protection. These systems are typically operated by purpose-specific government departments and staffed by social work professionals. Services are provided across three components: intake, investigation and case management.¹⁶⁴

The evidence suggests that extending child protection responses to include prevention and early intervention activities can achieve better outcomes.¹⁶⁵

We have also found that a socio-ecological framework to public health focuses on care and wellbeing, rather than only responding to abuse and neglect.

A socio-ecological framework can be applied to reorientate a child protection system to focus on prevention, early intervention and non-statutory response pathways. This recognises that violence, abuse and neglect result from the multiple influences of behaviours, often over time, including how individuals relate to each other and the broader environment.¹⁶⁶

Considering the many factors that contribute to child and family wellbeing includes protective factors and the strengths and assets of individuals, families and communities that assist them to overcome adversity (see further discussion on page **Error! Bookmark not defined.** above).¹⁶⁷

Figure 8 depicts a socio-ecological framework for child and family system, showing:

- the multiple levels involved in social services (such as individuals, families, groups, organisations and communities and systems and institutions)
- the external influences, such as the physical, social, policy and cultural environment, which includes structures, norms and practices
- the complexity of human experiences, such as the dynamic nature of people's interactions with their environment over time and the cumulative impact of events on life trajectories.

¹⁶³ Price-Robertson, R, Bromfield, L and Lamont, A, 2014, *International approaches to child protection: What can Australia learn?* Melbourne, Victoria: Child Family Community Australia

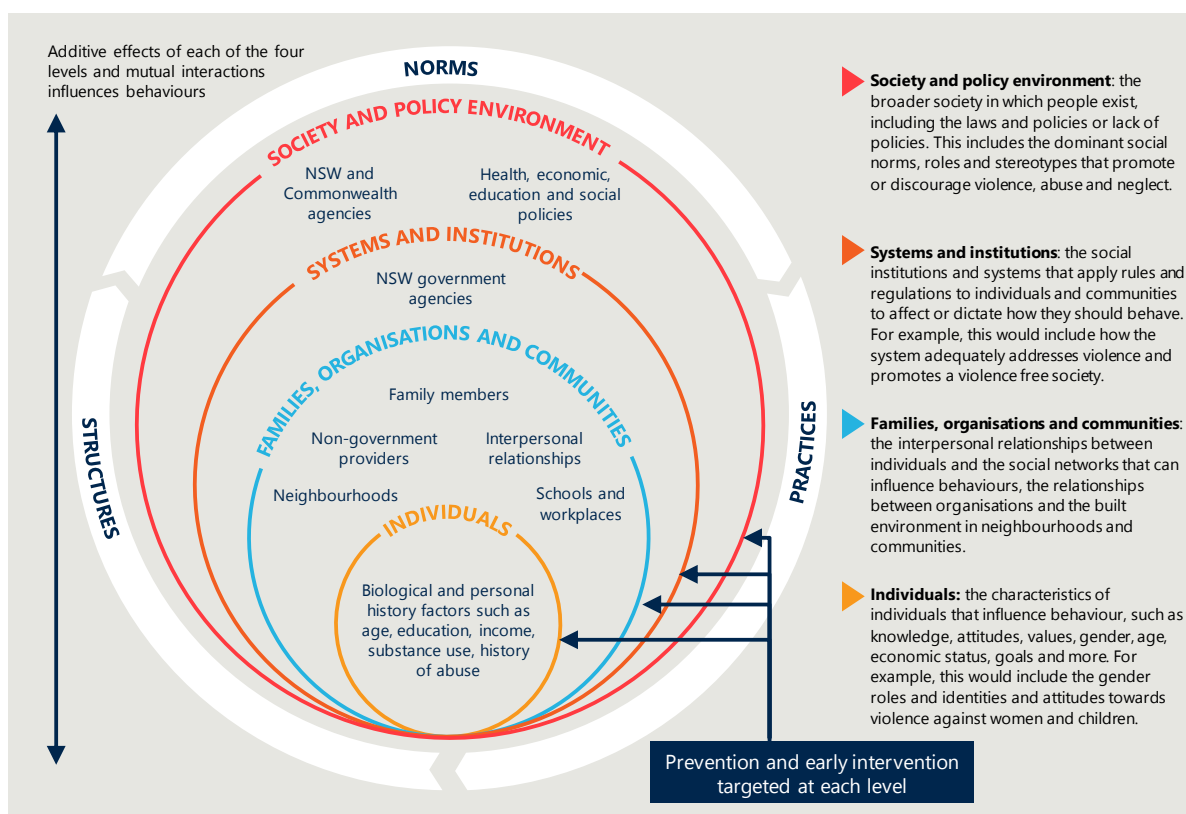
¹⁶⁴ AIHW, 2010, *Child protection Australia 2008-09*, Canberra, ACT: AIHW, referenced in Price-Robertson, R et al, 2014

¹⁶⁵ <https://www.ourwatch.org.au/getmedia/0aa0109b-6b03-43f2-85fe-a9f5ec92ae4e/Change-the-story-framework-prevent-violence-women-children-AA-new.pdf.aspx>

¹⁶⁶ Centre of Disease Control, n.d., *The socio-ecological model: framework for violence prevention*. Retrieved at: https://www.cdc.gov/ViolencePrevention/pdf/SEM_Framework-a.pdf

¹⁶⁷ National Alliance of Children's Trust and Prevention Funds, n.d., *Prevention of child neglect: the socio-ecological model*. Retrieved at: <http://www.ctfalliance.org/preventneglect/CN%20&%20Its%20Prevention%20Socio-Ecological%20Model.pdf>

Figure 8 | Socio-ecological framework applied to the NSW child and family system¹⁶⁸



As such, the socio-ecological framework proposes interventions at multiple layers, with a shift in focus from prevention to early intervention to reduce the incidence of violence, abuse and neglect against children (and their families). The statutory child protection system remains a necessary component, but the system scope widens to include:

- earlier intervention responses to address the underlying causes of violence, abuse and neglect in at-risk populations
- evidence-based, preventative approaches for individuals, families and communities.

The socio-ecological framework still assesses and responds to risk and child safety when necessary at the statutory level. However, it also includes different approaches for identification (such as soft entry points) and service responses (such as non-statutory pathways) across the spectrum of vulnerability. It necessitates a multi-agency response and aligns with the approach and design proposed by AbSec for a system that better meets the needs of Aboriginal children, families and communities. AbSec proposes a tiered system that includes universal supports at the community level and targeted prevention and response services at the individual and family level.¹⁶⁹

4.2 Core access system components

We have identified 10 models of practice that could form part of the Access System Redesign. We categorised these based on whether they relate to the identification, engagement and assessment,

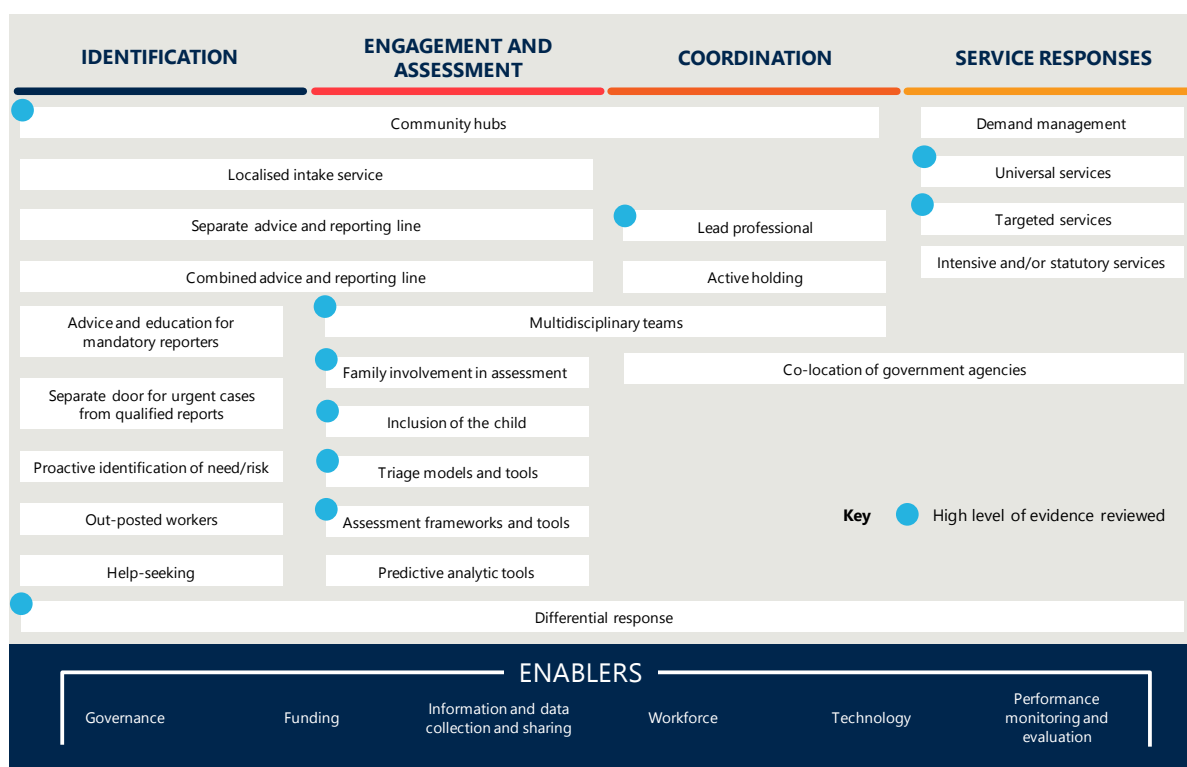
¹⁶⁸ Adapted from Our Watch, Australia's National Research Organisation for Women's Safety (ANROWS) and VicHealth, 2015, *Change the story: A shared framework for the primary prevention of violence against women and their children in Australia*. Melbourne: Our Watch and Centre for Disease Control, n.d., *The Social-Ecological Model: A Framework for Violence Prevention*. Retrieved at: https://www.cdc.gov/ViolencePrevention/pdf/SEM_Framework-a.pdf

¹⁶⁹ AbSec, 2016, *Achieving a holistic Aboriginal Child and Family Service System for NSW*. Sydney: AbSec.

coordination or services response for vulnerable children and families (definitions are provided in Appendix B).

Table 9 shows the models of practice we examined, and the work of and reports we commissioned. The section below provides the evidence for the ten models of practice identified with a high level of evidence. Appendix B details a further 14 models or practice for which we found low or medium levels of evidence.

Figure 9 | Models of practice examined as part of this evidence review



Rather than recommend on models of practice we have outlined the evidence on what exists for these models of practice in NSW and examples of good practice in other jurisdictions to inform the detailed design phase of the Access System Redesign. We have noted where each of these align with the key design elements of the Access System Redesign.

4.2.1 Community hubs

Community hubs identify vulnerable children and families, but their functions typically stretch across other components of the access system, including engaging and assessing families, referring to services and coordinating support. This evidence supports key system element 2: Community Hubs.

The community hub model is often a manifestation of a broader philosophy of a community-led response to child wellbeing and protection. It seeks to address issues holistically and consider the broader socio-economic system in which children and families exist.¹⁷⁰

How community hubs operate and the services they provide can differ, but typically they function as a community-led one-stop shop within either geographical or identity-based communities, managed by

¹⁷⁰ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

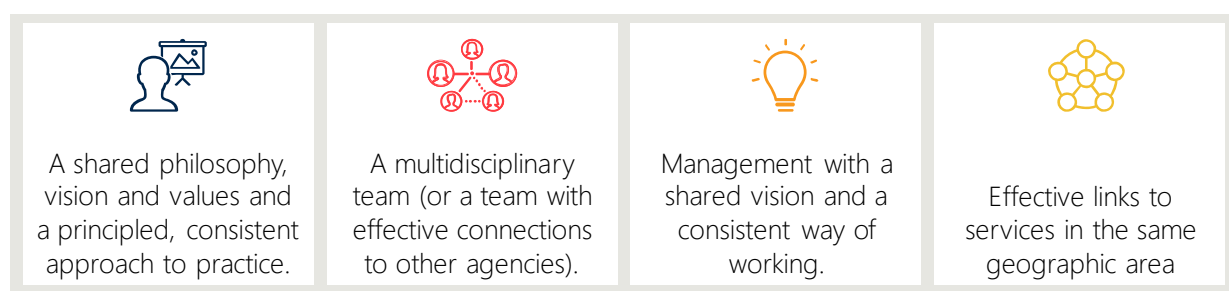
non-government organisations (NGOs) or Aboriginal community-controlled organisations.¹⁷¹ Successful community hubs are:

- informed by evidence-based practices proven to enhance social and economic supports and cohesion
- a trusted, culturally appropriate space for people to understand service availability and be referred to services
- embedded within the community with mechanisms to identify and respond to local needs
- able to link a family to spectrum of services, including early childhood, health, housing, parenting and other services
- often providing informal and formal services and support.

Evidence shows that the provision of robust advice and referral services using a community-hub style model – including the ‘one front door’ concept - can improve outcomes for children and reduce pressure on statutory services.¹⁷²

One research paper identified four features of effective community hubs, shown in Figure 10.

Figure 10 | Features of an effective community hub¹⁷³




A report from the Parenting Research Centre found that single entry points that have a local focus and staffed by local experts can improve understanding of the access system, improve referral to services and maintain relationships with families. This is particularly important for Aboriginal families.¹⁷⁴

Examples and evidence from NSW

Table 6 shows examples of existing community hub-style approaches in NSW.

Table 6 | Evidence on the effectiveness of existing community hub approaches in NSW


Service	Description	Evidence
 <p>Aboriginal Child and Family</p>	<p>This service model is based on evidence of the importance of providing a coordinated system of early childhood and basic health supports and services for children and families from prenatal to preschool. The aim is to remove the burden on parents to identify and seek support and to integrate the early childhood assets of a community</p>	<p>The centres provide a network of integrated and culturally appropriate services, tailored to the needs of the local community.</p> <p>There is evidence of increased uptake of universal services: 99 per cent of Aboriginal children attending the centres have been immunised and 83 per cent now enrolled in</p>

¹⁷¹ There are numerous community hubs in NSW that are managed by local councils and local community-based organisations. For example, the membership of the Local Community Services Association of NSW shows many examples.

¹⁷² Department of Health and Human Services, 2016, *Strong Families – Safe Kids: Implementation Plan 2016-2020*. Hobart: State of Tasmania.

¹⁷³ Kimbrough-Melton RJ and Campbell D, 2008, *Strong communities for children: a community-wide approach to prevention of child abuse and neglect*. Journal of Family and Community Health 31(2), pp100-112.

¹⁷⁴ Boston Consulting Group, 2018, *Access Redesign: high level future design and gap analysis*. Unpublished.

Centres - NSW ¹⁷⁵	– as well as to engage Aboriginal families in a culturally appropriate way. The centres are funded to provide early childhood and basic health but often provide other universal and specialist services.	early childhood education and care had not previously used this type of service. Families with complex needs and families at risk of child protection interventions are supported by the centres, preventing children from moving into the child protection system. ¹⁷⁶
 FACS Community Builders - NSW	FACS Community Builders are neighbourhood centres that receive funding to address disadvantage and promote inclusion with the aim of building stronger communities.	Neighbourhood centres improve outcomes for children and families by: <ul style="list-style-type: none"> • providing a range of direct services • acting as a conduit to other services • providing indirect benefits such as improving social networks and building social capital.¹⁷⁷

Examples and evidence from other jurisdictions

Table 7 outlines examples and evidence of community hub approaches in other Australian and international jurisdictions. This demonstrates the diversity of models available and the emerging evidence of effectiveness, including improved developmental, social and behavioural outcomes for children.

¹⁷⁵ Cultural and Aboriginal Research Centre Australia, 2014, *Evaluation of NSW Child and Family Centres: Final Report*. Sydney: NSW Department of Family and Child Services.

¹⁷⁶ Cultural and Indigenous Research Centre Australia (CIRCA), 2014. *Evaluation of NSW Aboriginal Child and Family Centres Final Report*.

¹⁷⁷ Gul Izmir, Ilan Katz and Jasmine Bruce (2009), *Neighbourhood and Community Centres: results for children, families and communities*. Social Policy Research Centre, University of New South Wales.

Table 7 | Evidence on the effectiveness of existing community hub approaches in other jurisdictions

Service	Description	Evidence
 <p>National Community Hub Program - Australia</p>	Community hubs are based in or closely linked to schools. They are intended to increase the inclusion and engagement of families from diverse cultural backgrounds into the life of the school and the community and to facilitate families' access to service supports.	Hubs are reaching newly arrived and migrant families and being highly responsive to their needs. Hubs have worked with families to break down social isolation, connect families with appropriate services and build connections between more established communities and new arrivals. ¹⁷⁸
 <p>Early Years Centres (EYCs) - Queensland¹⁷⁹</p>	The Queensland Government established EYCs in 2006, with four centres each with satellite services in neighbouring communities. They are based on research that indicates integrated early years services deliver greater benefits for children, families and communities. The EYCs provide universal early childhood education and care, health and family support services to families who are expecting a child or have children up to eight years of age. They are a one stop shop to deliver or broker universal services, targeted services and/or referrals to specialist or intensive support services.	There is evidence of improved developmental, social and behavioural outcomes for children, parenting skills and family wellbeing outcomes. Other outcomes included strong partnerships with other organisations and satellite services, community engagement and capacity building. These outcomes were achieved through the governance strategy, sectoral engagement, community connections, physical design of the space and flexible services and effective integrated service delivery. ¹⁸⁰
 <p>The Orange Door - Victoria¹⁸¹</p>	These hubs aim to mobilise the service system to work with women, children and families experiencing DFV and families in the need of support and to care for children and young people and perpetrators of DFV. They provide wraparound support, including help with the initial service contact, screening, risk assessment, crisis response, needs assessment and system navigation. The network of hubs include community-based hubs, satellite access points (for rural and Aboriginal communities), outposted workers and outreach/mobile services.	While there is no evaluation of this model, the process to develop the hubs involved detailed user experience design. The model, therefore, responds to the behaviours, cues and supports people who reported that they require a sense of safety and comfort.
 <p>Child and Family Assessment and Referral Networks – SA¹⁸²</p>	South Australia's Department of Child Protection is piloting a Child and Family Assessment and Referral Network, which will offer an alternative to OOHC by linking people to family support services, early intervention and family preservation services. The Network will partner with Aboriginal services to provide culturally sensitive responses and expand service options for Aboriginal families who may need help to care for children.	The effectiveness of this model has not been evaluated.
 <p>Family Centres and Children's House - Sweden¹⁸³</p>	Sweden's family centres are free, voluntary, universal and integrated centres that provide multidisciplinary services (health, counselling, social welfare and more). The 300 children's houses, embedded in communities, are a multi-agency, one stop shop model, and a child-friendly space to conduct all components of a child abuse investigation. It involves the prosecutor, police, social services, health services and psychiatric care.	A research study conducted with 12 children and 22 parents at different children's houses found that 'both children and parents appreciated the child-friendly and safe environment and kind treatment by the staff.' ^{203'} No more rigorous quantitative evaluations were identified.

¹⁷⁸ Press, F., Wong, S., Woods, A., Miller, M., Rivalland, C., & Sumsion, J. (2015). Independent Evaluation of the National Community Hubs Program. Wagga Wagga, NSW: Research Institute for Professional Practice, Learning and Education (RIPPLE).

¹⁷⁹ Whalley M, 2006, *Children's centres: the new frontier for the welfare state and the education system? Engaging with the struggle*. Northamptonshire: Pen Green Research, Training & Development Base

¹⁸⁰ Department of Education, Training and Employment, 2013, *Evaluation of the Early Years Centre initiative*. Brisbane; Department of Education, Training and Employment.

¹⁸¹ Victorian Government, 2017, *Support and safety hubs: state-wide concept*. Unpublished. Family Safety Victoria, 2018, *Support and Safety Hubs Client Experience Design, Phase 1 Report: Findings to inform Hubs implementation and ongoing design*. Unpublished.

¹⁸² Department for Child Protection, 2018, *Child protection: a fresh start. Progress report June 2018*. Adelaide: Government of South Australia.

¹⁸³ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

4.2.2 Multidisciplinary teams

Multidisciplinary teams (MDTs) can also be used in the coordination and service delivery stage, including helping vulnerable families navigate through the system. This evidence supports key system element 3: Multi-agency service coordination.

This model of practice refers to a collection of professionals from a range of disciplines working collaboratively to engage and assess children and families. Child abuse investigations and family assessments are inherently complex and require input and action from many agencies and providers. MDTs may be referred to as a 'child protection teams', 'interdisciplinary teams' or 'case consultation teams'. MDTs may be co-located and commonly include representatives from child protection, law enforcement, physician or medical providers, mental health professionals and victim advocates.

MDTs in Australian and international jurisdictions:

- better coordinate investigation, prosecution and case management
- reduce the number of times a child and family must repeat information
- achieve timely and efficient information sharing (verbal can be faster than written)
- allow quality referrals and coordination of cross agency responses
- achieve greater joint accountability of outcomes.¹⁸⁴

Examples and evidence from NSW

Joint investigative response teams (JIRTs) are made up of FACS, NSW Police and NSW Health professionals who jointly investigate child protection matters when there is a possibility that the abuse constitutes a criminal offence. In 2017, an independent review of the JIRT program found that it represents a comprehensive, consistent and coherent State-wide strategy for cross-agency responses to child abuse.¹⁸⁵ JIRTs reduce negative experiences for children and families during investigation responses while facilitating multi-agency information sharing and joint planning and response.¹⁸⁶

The **Family Investment Model** is a localised, multidisciplinary approach being piloted in Dubbo and Kempsey that involves FACS, Juvenile Justice, Corrective Services, NSW Police, the Department of Education and the NSW Health working together to develop family assessment and case management plans. The Australia Institute of Criminology will evaluate the model when the pilot is completed.¹⁸⁷

Examples and evidence from other jurisdictions

Figure 11 illustrates MDTs in Victoria, Western Australia, Northern Territory and Queensland and their varying roles, composition and scope. Common to all models is the involvement of child protection and police services and cross-agency case planning, protocols and specialist infrastructure such as interview suites. Appendix C details the models and evidence of their effectiveness.¹⁸⁸

Figure 11 | Agency involvement and key roles of MDTs across Australian jurisdictions¹⁸⁹

¹⁸⁴ Herbert J and Bromfield L, 2017, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse – A Report for the NSW Ombudsman's Office*. Adelaide; Australian Centre for Child Protection, University of South Australia. Centre of Excellence for Information Sharing, n.d., *Multi-Agency Safeguarding Hubs*. s.l.; Centre of Excellence for Information Sharing. Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.; Australian Catholic University.

¹⁸⁵ NSW Ombudsman, 2017, *The JIRT Partnership – 20 years on: NSW Ombudsman inquiry into the operation of the JIRT program*. Sydney; State of New South Wales.

¹⁸⁶ Boston Consulting Group, 2018, *Access System Redesign Compendium*. Unpublished.

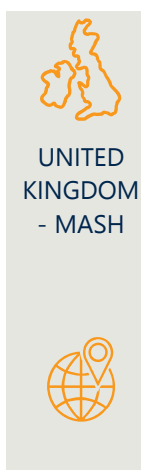
¹⁸⁷ Parliament of NSW, Legislative Assembly Hansard 21 Nov 2017, Troy Grant, Dubbo Electorate Family Investment Model

¹⁸⁸ Herbert J and Bromfield L, 2017, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse – A Report for the NSW Ombudsman's Office*. Adelaide; Australian Centre for Child Protection, University of South Australia.

¹⁸⁹ Ibid.

	Co-located JIRTs (NSW)	MDC pilots (Victoria)	SCAN Teams (Queensland)	MIST pilot (WA)	Child Abuse Taskforce (NT)
Agency involvement					
Child protection					
Police					
Health					
Support services					
Education					
Key characteristics of response					
Cross-agency protocol					
Cross-agency intake					
Case review/planning					
Joint-agency investigation					
Co-location of core agencies					
Co-location of support agencies					
Specialist interview suites					
Cross-agency input & observation of interviews					
Built-in independent advocacy role					

We have identified three examples of MDTs in international jurisdictions for which there was some evidence on the impact and effectiveness.



The Multi-Agency Safeguarding Hub (MASH) acts as a single point of entry; enables thorough research of each case to identify potential risk; shares information between agencies; triages referrals; facilitates early intervention; and manages cases through coordinated interventions. Children's social care, police, health, education, probation, housing and youth offending agencies are involved.

A study of five London boroughs found that MASH had achieved a more accurate assessment of risk and need and improved the suitability and timing of service response for families.¹⁹⁰

MDTs are used to investigate and prosecute child abuse cases to coordinate the responses of all the agencies involved in the investigation, prosecution and case management of child abuse. MDTs can include members from child protective services, law enforcement, the district attorney's office, a physician trained in forensic paediatrics, a mental health

¹⁹⁰ Centre of Excellence for Information Sharing, n.d., *Multi-Agency Safeguarding Hubs*. s.l.; Centre of Excellence for Information Sharing. Unknown author, 2014, *Multi Agency Working and Information Sharing Project: Final Report*. s.l.; Home Office.

US (New
York) -
MDTs



New
Zealand –
Children’s
Teams

professional, a victim advocacy personal and, if one exists, a child advocacy centre. This is similar to JIRT, but with a greater emphasis on improving the experience for the child.

A systematic study of New York’s MDTs found significant variability in performance. Overlapping functions and lack of appreciation of the value and role of family support services impeded team integration and optimal coordination and planning.¹⁹¹

Children’s Teams include all parties needed to address a vulnerable child’s needs including practitioners and professionals from health, justice, education and social services. Unlike many traditional MDT models, Children’s Teams focus on children not at ROSH up to 18 years old.¹⁹² Initial indications show that implementation has been poor and scaling the design is a challenge.¹⁹³

¹⁹¹ Boston Consulting Group, 2018, *Access System Redesign Compendium*. Unpublished. Office of Children and Family Services, 2018, *Child Protective Services Manual: Chapter 6: Child Protective Services Investigations – Revised Aug 2018*. New York; New York State. Kutash K, Acri M and Pollock, M, 2013, *Quality Indicators for Multidisciplinary Team Functioning in Community-Based Children’s Mental Health Services*. s.l.;

Administration and Policy in Mental Health and Mental Health Services Research.

¹⁹² Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

¹⁹³ Boston Consulting Group, 2016, *User needs analysis and segmentation*. Unpublished.



Evidence on MDT models for Aboriginal children and families

We identified one example of an MDT model adapted to better meet the needs of Aboriginal children and family.

When the Queensland Department of Communities (Child Safety Services) is required to intervene with Aboriginal children and young people, a recognised entity - an Aboriginal organisation or individual who is approved and funded by the department to provide cultural and family advice for Aboriginal child protection matters - must be involved in the decision-making. The recognised entity will provide information and advice to the department so that decisions affecting Aboriginal children and young people maintain their sense of identity and their links with family, community and culture. A recognised entity must be involved in all steps in the child protection process, including in suspected child abuse and neglect team meetings.¹⁹⁴

4.2.3 Family involvement in assessment

Family involvement in assessment is one aspect of the broader principle of voice of the family, an approach or philosophy that can underpin all components of an access system. Learnings on how families can be better involved in the assessment stage may be applied to other model of practices.

This model of practice refers to policies, practices and processes that empower and enable families to have a role in the assessment of the risks and needs of their child and family. Meaningful participation is defined as informing, hearing and involving.¹⁹⁵ It encompasses how:

- families are made aware of their rights, services and support available to them
- trust is established between assessors and families
- families can contribute their views on what the best outcome is for the child and the family
- these views are listened to and considered when determining what the best outcome is for the child, young person and family
- families, children and professionals can share their understanding of the most effective response.¹⁹⁶

Evidence shows that greater involvement of the family in the assessment and determination of a child's future achieves better outcomes and promotes family buy-in into the process.¹⁹⁷ However, this can be difficult when people are involuntary participants or reluctant or unwilling to be involved.

Examples and evidence from NSW

Family Group Conferencing brings family members together in a positive way with an impartial facilitator to plan for a child or young person.¹⁹⁸ An evaluation of the pilot program indicated the program delivered some positive short-term outcomes for the families and professionals involved, yet there was not sufficient evidence to support a recommendation to continue the program beyond the pilot period.¹⁹⁹

¹⁹⁴ Herbert J and Bromfield L, 2017, *Multiagency Investigation & Support Team (MIST) Pilot: Evaluation Report*. Adelaide; Australian Centre for Child Protection. Department of Communities, Child Safety and Disability Services, 2013, *Carer fact sheet 7: Providing foster and kinship care: The role of the Recognised Entity*. s.l.; State of Queensland.

¹⁹⁵ Bouma H, Lopez M, Knorth E, Grietens H, 2018, *Meaningful participation for children in the Dutch child protection system: A critical analysis of relevant provisions in policy documents*. Groningen; Child Abuse & Neglect, 79, 279-292.

¹⁹⁶ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.; Australian Catholic University. Unknown author, 2014, *Family Assessment Response (FAR) FactSheet*. New York; Schuyler Center for Analysis and Advocacy.

¹⁹⁷ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.; Australian Catholic University.

¹⁹⁸ NSW Family and Community Services, n.d., *Family group conferencing – Information for children and young people*. s.l.; NSW Government.

¹⁹⁹ Australian Institute of Criminology, n.d., *Evaluation of the Family Group Conferencing pilot program: Summary of key findings*. s.l.; Australian Government.

The **Practice First Framework** is a child protection service delivery model designed for the range of statutory child protection work from assessment to OOHC. It focuses on changing the practice culture across assessment, intervention and collaboration with partner agencies. Practice First aims to achieve safety for children and families through skilful child protection practice, shared management of risk and building genuine relationships with families and the community. A 2016 evaluation found it improved relationships between caseworkers and families, built families' understanding and led to more meaningful client engagement.²⁰⁰

Examples and evidence from other jurisdictions

Family Group Conferencing is also used in Queensland. A family group meeting, held when a child is believed to need protection, brings together the immediate and other family members or people who have a significant relationship with the child. Family members discuss the strengths and needs of the family, who will help the family meet these needs and how these needs will be met. We were unable to identify evidence on effectiveness or outcomes.²⁰¹

Considered removal family team meetings used in Connecticut are mandatory meetings held before a decision is made to remove a child, with the involvement of families, lawyers and providers. They bring all members involved in the child's life to discuss and determine the next course of action, with a focus on how the child can remain in the home.²⁰² Since implementation in 2013, a high number of OOHC placements have been diverted because of this model.²⁰³

New York's **Family Assessment Response** is an alternative child protection response that uses a family-centred, family-led approach to effectively engage families in assessing their needs and strengths. Table 10 details a case study of this model.

The **Youth Justice Family Group** in New Zealand is a group conference arranged by a youth justice coordinator with a young person who has committed an offence, their family, victims and professionals. The conference aims to find practical ways for the young person to make amends through community service or part-time job to pay for damages. The family can discuss how the crime impacted them and the plan is confirmed with the family and young person.²⁰⁴

Ireland's **Meitheal model** targets children and families in need of support who do not meet the threshold for child protection intervention. A Meitheal support group is a multi-agency group that includes the parents of the child and young person where appropriate. Parents are involved in the children or young person's action plan which gives them a sense that they are worthwhile and capable.²⁰⁵

4.2.4 Inclusion of the child

Inclusion of the child in the engagement and assessment phase is one aspect of the broader principle of Voice of the Child that can underpin all components of an access system. Learnings on how children can be included in the assessment stage may be applied to other models of practice in the access system.

²⁰⁰ Wade, C, Mildon R, Shlonsky A, Katz, I, Valentine, K, Eastman, C, Cortis, N, Smyth, C, Forbes, F, 2016, *Practice First Evaluation Report*. Melbourne; Parenting Research Centre.

²⁰¹ Department of Communities, Child Safety and Disability Services, n.d., *Family group meetings Information for families*. s.l.; State of Queensland.

²⁰² Luczak S, Updegrove N and Ruth L, 2018, *Between People and Places: Reducing Upheaval for Children Moving Around in Connecticut Foster Care*. New Haven; Connecticut Voices for Children.

²⁰³ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.; Australian Catholic University.

²⁰⁴ TFM, 2018, *New Zealand & Voice of the Child*. Unpublished.

²⁰⁵ Cassidy, A, Devaney, C, McGregor, C, 2016, *Early Implementation of Meitheal and the Child and Family Support Networks: Lessons from the field*. Galway; The UNESCO Child and Family Research Centre, The National University of Ireland. Devaney, C, McGregor, C, Cassidy, A, 2017, *Early Implementation of a Family-Centred Practice Model in Child Welfare: Findings from an Irish Case Study*. Taylor & Francis Online.

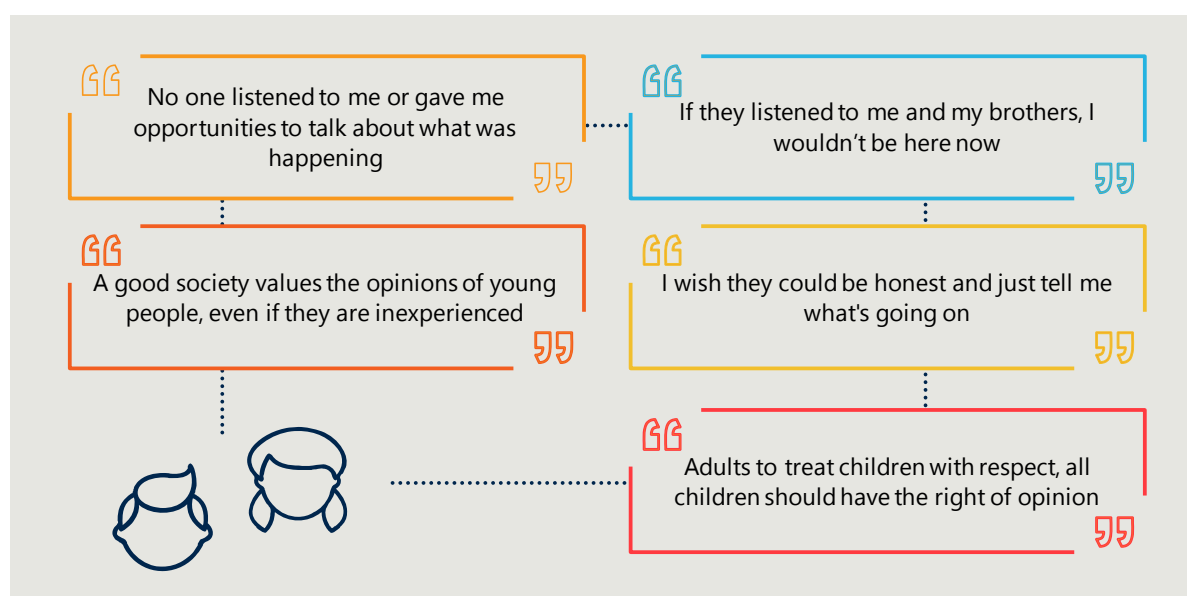
Inclusion of the child refers to policies, practices and processes to place children at the centre of the access system to give them a role and a voice in decisions made about their lives, including through the assessment process. As with family involvement, meaningful participation is essential.

Child protection services have traditionally sought to protect a child from future risk of harm, but little attention has been paid to the agency of the child.²⁰⁶ Emerging evidence indicates that inclusion of the child's views and desires increases the likelihood of a positive long-term outcome for that child.²⁰⁷ The evidence on effective child inclusion mechanisms in Australia and internationally²⁰⁸ shows that tailored tools and explicit mechanisms and practices to enhance child engagement in the social services can enable 'richer, more productive interactions between social service practitioners and the people they work with'.²⁰⁹

Examples and evidence from NSW

Consultations with children and young people in 2016-2017 highlighted the importance of including their voice during assessment, case planning and service delivery. Children and young people reported positive experiences with workers who were determined to meet their needs and that they wanted workers who truly listen, can see them often on a one-to-one basis, and emphasise their voice over family restoration.²¹⁰ Figure 12 highlights quotes from children and young people in contact with child and family services about their experiences of inclusion.

Figure 12 | Quotes from children and young people in contact with child and family services²¹¹



²⁰⁶ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

²⁰⁷ Bouma H, Lopez M, Knorth E and Grietens H, 2018, *Meaningful participation for children in the Dutch child protection system: A critical analysis of relevant provisions in policy documents*, Volume 79, pp, 279-292. s.l.: Child Abuse and Neglect.

²⁰⁸ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

²⁰⁹ Lonne B, 2018, *Triage and Assessment Tools: Accessing Help through the Front Door*. Armidale; University of New England.

²¹⁰ Advocate for Children and Young People, 2016, *NSW Strategic Plan for Children and Young People – Consultation Results*. s.l.; Office of the Advocate for Children and Young People. Advocate for Children and Young People, 2017, *Consultation Report: What children and young people experiencing homelessness have to say*. s.l.; Office of the Advocate for Children and Young People. Advocate for Children and Young People, 2017, *Consultations with children and young people about violence - What children had to say*. s.l.; Office of the Advocate for Children and Young People. Advocate for Children and Young People, 2017, *Students views on support services for youth mental health and wellbeing*. s.l.; Office of the Advocate for Children and Young People. Higgins, D, 2015, *A public health approach to enhancing safe and supportive family environments for children*. s.l.; Family Matters (96), 39-52.

²¹¹ Ibid.

Our TFM-CREATE workshop at the ACWA conference in August established recommendations to improve the inclusion of the child in NSW:

- give caseworkers more opportunities to have safe, ongoing conversations with children and young people
- improve access to information for children and young people about their rights including through different modes such as a book, an app or, a website
- allow genuine contribution by young people to their after-care plan
- develop mechanisms to enable child and young people to provide feedback on the system.²¹²

The **JIRT model**, already detailed, allows teams to conduct interviews in an environment focused on the child and young person and promotes their participation. JIRTs can reduce negative experiences for children and families during investigation responses.²¹³

The innovative children and young people **Inspectors Program** trains children and young people to review services and provide feedback to providers and government. We were unable to identify an evaluation of this program.²¹⁴

Examples and evidence from other jurisdictions

The **Viewpoint Interaction Program** in Western Australia is a child-friendly way for children and young people to use computers to develop their care plans and provide feedback on their experiences. Children and young people report that it is easy to use, questions are relevant and they would like to use again.²¹⁵

The **Office of the Public Guardian community visitors** in Queensland support children and young people to ensure their views and wishes are heard and their needs are met. Community visitors are independent. We did not identify an evaluation of this program.²¹⁶

New Zealand's **Voice of the Young and Care Experienced** provides an independent voice for children and young people within the care system. The Youth Council of Care Experienced Young People provide advice and promote the voice of care experience. We did not identify an evaluation of this program.²¹⁷

Another New Zealand initiative, **Tuituia Framework** emphasises the agency and strengths of a child, and is underpinned by 'Mokopuna Ora' – Child or Young Person's Holistic Wellbeing. The framework places their individual aspirations and potential at the centre of decision-making. We did not identify an evaluation of this program.²¹⁸

Children's House in Sweden. Children's Houses' are a multi-agency, child-friendly space to conduct a child abuse investigation. Research conducted with 12 children and at different centres found that children appreciated the environment and the treatment by staff.²¹⁹

Scotland's **Getting It Right for Every Child Framework** uses an assessment model that considers the child's wellbeing. At a universal level, children are encouraged to add their perspective to a determination of their wellbeing. Evidence from a 2015 survey with children and young people in East Ayrshire found 79

²¹² TFM, 2018, *TFM/CREATE Client Voice Workshop*. Unpublished.

²¹³ Boston Consulting Group, 2018, *Access System Redesign Compendium*. Unpublished.

²¹⁴ Wise S, 2017, *Developments to strengthen systems for child protection across Australia CFCA Paper No. 44*. Melbourne; AIFS.

²¹⁵ Department for Child Protection and Family Support, 2016, *Viewpoint: Information for carers Information Sheet*. s.l.; Government of Western Australia. Wise S, 2017, *Developments to strengthen systems for child protection across Australia CFCA Paper No. 44*. Melbourne; AIFS.

²¹⁶ Office of the Public Guardian, n.d., *Community visitor*. Retrieved at <https://www.publicguardian.qld.gov.au/i-am-a-child-or-young-person/who-can-help-you/community-visitors>.

²¹⁷ Voyce Whakarongo Mai, n.d., *Amplifying your voices and standing up for you*. Retrieved at <https://www.voyce.org.New Zealand/>.

²¹⁸ Orange Tamariki Practice Centre, 2013, *The Tuituia assessment framework guidelines*. Retrieved at <https://practice.orangatamariki.govt.nz/Zealand/policy/assessment-and-decision-making/resources/the-tuituia-assessment-framework-guidelines/>.

²¹⁹ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

per cent agreed or strongly agreed with the statement 'My views are considered and can lead to changes.'²²⁰

Extended timeframes for assessment and decision-making in Norway and Finland recognises that genuine and meaningful participation of children can take a considerable amount of time. Generous timeframes for decision-making is identified as a key factor to a child's successful involvement. Finland is considered to provide the greatest participation of children and families in its welfare system. A 2009 study on care and protection cases in Norway found effective participation of children in 46.5 per cent of cases.²²¹

Thirty-five local authorities in England adopted the **Signs of Safety approach** in 2011, which includes tools that help children to understand what has happened and why they are involved with services and creates an opportunity for children to be heard. A review on the experiences of practitioners who have used the Signs of Safety tool showed that it helped younger children have a voice and helped parents see things from the child's perspective.²²²

4.2.5 Triage models and tools

It is difficult to separate the evidence on triage and assessment approaches, models and tools as they are closely linked and are sometimes referred to interchangeably. The content of this sub-section should be read alongside 4.2.6 on Assessment frameworks and tools.

Triage refers to the processes in which children, young people and families are screened or assessed to determine the level of priority of risks or needs. The Parenting Research Centre defined triage as the 'determination of which cases are urgent and require intensive services versus those which require a non-urgent response or less intensive services'.²²³ Triage is a form of demand management and prioritises children and young people at the highest risk in a system with finite resources. Where there is more than one triage in an access system, the first triage is sometimes referred to as pre-screening.

The three types of tools typically used at triage (and assessment) include:

- *Theoretical or consensus-guided tools* - theoretical approaches identified by experts through clinical experience or research.
- *Actuarial tools* - tools that are empirical, validated statistically and incorporate risk factors weighted on key factors and scaled to provide evidence of risk. The most widely used actuarial tool is Structured Decision-Making Tool, used in the United States (23 states), Canada (five provinces) and Australia (four states). All jurisdictions modify the risk assessments to the context of their jurisdiction. The Structured Decision-Making Tool has a stronger evidence base than other risk assessment tools.
- *Clinical practice judgement* - uses structured guidelines, some of which are empirically based, but which leave the final decision-making process to the professional. Evidence suggests that these tools can be prone to human error and bias.²²⁴

Two reviews that examined triage (and assessment tools) found a limited evidence base for the use of any single screening or assessment tool. Reviews of the use of various tools showed that a variety of actuarial and consensus-based tools are increasingly being used and adopted, often within localised comprehensive practice frameworks. These are more accurate than clinical judgement alone. Evidence

²²⁰ Ibid.

²²¹ Michail S, 2018, *Voice of the Child, Family and Community Project: Jurisdictional Analysis*. Unpublished.

²²² Ibid.

²²³ Parenting Research Centre, 2018, *Access system redesign – a rapid evidence assessment of models of triage and segmentation*. Melbourne: Parenting Research Centre.

²²⁴ University of New England, 2018, *Triage and Assessment Tools: Accessing Help through the Front Door*. Armidale; University of New England.

suggests that structured actuarial tools classify cases more accurately and have greater predictive power than consensus risk models. However, researchers argue that these methods over focus on procedure and a minimisation of complexity.²²⁵

Examples and evidence from NSW

In NSW, initial triage occurs at the Child Protection Helpline and assessment is focused on maltreatment or risk of maltreatment, rather than need. The *Independent Review of Out of Home Care in NSW* (2016) (the Tune Review) identified an opportunity to standardise triage tools in NSW.²²⁶

Triage (and assessment) tools in NSW include:

- *Screening and Response Priority Tools (SCRPT)*. Case workers at the helpline use SCRPT to determine whether a report meets the ROSH threshold and, if so, how quickly FACS should respond to the report.²²⁷ A 2018 case reading review of the application of SCRPT found that Helpline caseworkers continue to use the tools correctly and make good decisions based on them in approximately 80-90 per cent of cases.²²⁸
- *Safety Assessment, Risk Assessment and Risk Reassessment (SARA)*. After SCRPT is applied, the report is transferred to a local office for a SARA assessment, a structured decision making (SDM) tool that helps caseworkers assess safety and risk in relation to children, their parents and families/kin they visit. Three components to the SARA tool are completed at specific periods in time for a family: a safety assessment, risk assessment and risk reassessment. We have not identified any evaluation of SARA in the NSW context.²²⁹
- *Mandatory Reporters Guide (MRG)*.²³⁰ The MRG plays a key role in determining which cases – and how many – get referred to Helpline. It was developed to ensure that the types of concerns referred to Helpline by mandated reporters could be congruent with the new ROSH threshold. Moreover it provided guidance and intervention options for reporters to use with those cases that would no longer be referred to Helpline. Those options included referral to a Child Wellbeing Unit (CWU), direct referral to services, or documenting the concern and continuing the relationship with the child and family.

Table 8 details the evidence on the use of triage tools in international jurisdictions. The focus of each tool differs (for example, on primary-care giver to risk of physical abuse) as does who administers the tool (for example, child welfare workers to public health nurses).

The most widely used actuarial tool is SDM. Other tools include Washington Risk Assessment Matrix, the California Family Assessment Factor Analysis, the Child at Risk Field System and The Child Emergency Response Assessment Protocol.

²²⁵ Parenting Research Centre, 2018, *Access system redesign – a rapid evidence assessment of models of triage and segmentation*. Melbourne; Parenting Research Centre. University of New England, 2018, *Triage and Assessment Tools: Accessing Help through the Front Door*. Armidale; University of New England.

²²⁶ Tune D, 2015, *The Tune Report: Independent review of OOHHC*.

²²⁷ University of New England, 2018, *Triage and Assessment Tools: Accessing Help through the Front Door*. Armidale; University of New England. Parenting Research Centre, 2018, *Access system redesign – a rapid evidence assessment of models of triage and segmentation*. Melbourne; Parenting Research Centre.

²²⁸ National Council on Crime & Delinquency, Children's Research Centre, 2018, *Helpline Use of the SCRPT Assessments: Case Reading Results*. Unpublished.

²²⁹ Ibid.

²³⁰ Mathews, B, 2018, *Research on Reporting of Child Maltreatment to inform High Level Design*. Brisbane; University of Queensland.

Table 8 | Analysis of triage tools²³¹

Tool	Type	Description	Evidence
California Family Risk Assessment	Actuarial	<ul style="list-style-type: none"> Used for assessment of risk after an initial report of concern Administered by child welfare workers. Assessment focused on primary care-giver and likelihood of physical abuse and future neglect. Workers can override the score 	Supports the use of this tool and indicates it has modest predictive value.
California Family Risk Assessment (revised by The Netherlands)	Actuarial	<ul style="list-style-type: none"> Administered by public health nurses during home visits and visits to the clinic Used without a report of maltreatment Added experimental risk factors regarding the secondary caregiver 	Shows that this tool has increased predictive value compared with the original California Family Risk Assessment
Child Abuse Potential Inventory	Actuarial	<ul style="list-style-type: none"> Assesses risk of physical abuse Administered by child welfare workers Consists of a 160-item self-report questionnaire 	One study reports that the Inventory correctly discriminates across a variety of cultures
Cleveland Child Abuse Potential Scale	Actuarial	<ul style="list-style-type: none"> Based on Child Abuse Potential Inventory and include both static and dynamic risk factors Administered by case workers 	One study indicates the negative environmental risk factors scale has significant predictive power
Family Risk Assessment for Abuse and Neglect	Actuarial	<ul style="list-style-type: none"> Actuarial assessment device 	A prospective evaluation by South Australian FACs established good predictive validity

Examples and evidence from other jurisdictions

Some jurisdictions use a pre-screening process or initial triage when a report of concern is first made. We found some evidence that this pre-screening process has reduced referrals or the number of children in OOHC. In all these jurisdictions, a social worker conducts the initial pre-screening:

- **Scotland.** A local social work service conducts the initial pre-screening to decide with police and in consultation with appropriate agencies whether to launch an investigation. Since implementation in 2008, the number of referrals to the Children's Reporter has decreased by 73 per cent.²³²
- **Connecticut.** A social worker conducts the initial pre-screening at the centralised 24-hour Careline to determine if the report meets legal sufficiency and, if so, the response time. The number of children in OOHC reduced from 6,046 in 2007 to 3,834 in 2015.²³³
- **New Zealand.** Initial triage is undertaken at the National Contact Centre by a social worker and classified as either a report of concern or contact record. A report of concern is distributed to the Ministry for Children at a local site office. Triage and assessment undertaken within the Tuituia Framework.²³⁴

²³¹ University of New England, 2018, *Triage and Assessment Tools: Accessing Help through the Front Door*. Armidale; University of New England.

²³² Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.; Australian Catholic University.

²³³ Ibid.

²³⁴ Ibid.



Calibrating culture within assessment tools

All jurisdictions are developing mechanisms to better support Aboriginal children and families and people from culturally and linguistically diverse backgrounds.²³⁵ The Access System Redesign will need to ensure that any new triage tool is developed in consultation with Aboriginal communities and families and supported by evidence that demonstrates the tool does not disproportionately impact Aboriginal families. We found evidence of two studies that explore the calibration of culture within triage tools:

- In the US, a study on the effects of SDM tools on racial disproportionality found no differences for white, Indian, Asian and Latino children, but that black children were more likely to be removed from home and more likely to have new child protection services referral than black children from earlier years. Researchers could not explain if this was due to the SDM tools or other unexplained fluctuations.²³⁶
- The evaluation of the Common Approach to Assessment, Referral and Support in four NSW, Victoria, Western Australia and South Australia indicated that Aboriginal workers thought the intensive questioning required in the administration of all the tools would be instructive and likely to make Aboriginal clients feel anxious.²³⁷

4.2.6 Assessment frameworks and tools

As noted above, it is difficult to separate the evidence on triage and assessment approaches, models and tools as they are closely linked and are sometimes referred to interchangeably. This sub-section should be read alongside 4.2.5 above. This evidence supports key system element 4: Need is matched to the right response

Assessment tools and frameworks help determine the level of risk and/or need experienced by children, young people and families and the appropriate service response or intervention. The assessment of risk and/or need occurs once a child, young people or family has entered the access system after initial triage.

Historically, assessment of risk and need was often unstructured, relying on the expertise of the assessment maker. The Australian and international shift to a standardised assessment framework²³⁸ provides greater guidance to the assessor and ensures consistency across a jurisdiction.

The evidence base for assessment tools varies. No tools appear to provide metrics that support their use without an override function based on professional judgment. Some research exists to indicate that actuarial models were the most accurate and that the Children's Research Centre Structured Decision-Making model used in California had a high degree of validity and reliability.²³⁹

Examples and evidence from NSW

There is no common and system-wide assessment framework or tools in NSW. The evidence indicates that SDM tools used by community services centres may have some predictive validity, although they have not been rigorously validated and may vary by demographic and case factors.²⁴⁰

²³⁵ University of New England, 2018, *Triage and Assessment Tools: Accessing Help through the Front Door*. Armidale; University of New England.

²³⁶ Miller M, 2010, *Structured Decision Making assessment: Does it reduce racial disproportionality in Washington's Child Welfare System?*. Washington; Washington State Institute for Public Policy.

²³⁷ University of New England, 2018, *Triage and Assessment Tools: Accessing Help through the Front Door*. Armidale; University of New England.

²³⁸ Australian Government AIFS, 2016, *Risk assessment instruments in child protection*. Retrieved from: <https://aifs.gov.au/cfca/publications/risk-assessment-child-protection>.

²³⁹ University of New England, 2018, *Triage and Assessment Tools: Accessing Help through the Front Door*. Armidale; University of New England.

²⁴⁰ Ibid.

We have commissioned research to underpin our evidence-based recommendations on how to improve the NSW approach to assessment tools. This research recommends:

- embedding needs assessments at the initial intake alongside a safety assessment, with risk assessment processes occurring when there is sufficient information to make this more accurate and reliable
- including an ethical framework with any application of assessment tools that includes a rights-based framework for children and families
- building on the existing FACS Practice Framework and adopting a robust practice framework across the sector that is based on relationships with people and provides ethical guidance.²⁴¹

Examples and evidence from other jurisdictions

Several Australian jurisdictions have introduced, or are planning to introduce, common assessment frameworks to share knowledge and capacity. The variety of assessment tools highlights that rather than a gold standard framework, jurisdictions adopt frameworks and tools suitable to their context. There is a trend towards more holistic assessment frameworks focused beyond risk. These frameworks include:

- *Western Australia: Signs of Safety (SOS) Child Protection framework.* Adopted in 2008, SOS encompasses broader framework principles but focuses on assessment. The assessment and planning protocol maps the harm, danger, complicating factors, strengths, existing and required safety and a safety judgement in situations where children are vulnerable or have been maltreated.²⁴²
- *Western Australia: Common Risk Assessment Risk Management Framework.* This framework is focused on DFV but can be applied to child protection concerns. An evaluation in 2013 showed a positive impact in relation to screening, risk assessment and improved knowledge and confidence when responding to family and DFV.²⁴³
- *Tasmania:* Tasmania's new approach will include:
 - *Common Approach Framework.* While not a risk assessment tool, the Common Approach Framework provides a common language and consistent way for service providers to evaluate and discuss the strengths and needs of a family, child or young person. This will build a cohesive understanding of risks across the system. The framework requires providers to question '*what is required to build strength in this family to protect this child*'. Uptake of Common Approach Framework has been limited and fragmented.²⁴⁴
 - *Risk Framework.* The *Strong Families Safe Kids Implementation Plan* commits to a State-wide risk assessment framework to build a greater understanding across the child and family service system of when government services and authorities need to intervene. The *Common Risk Assessment Framework for Risks to the Wellbeing of the Child* is to be released in 2018.²⁴⁵
- *Queensland: Collaborative Assessment and Planning Framework.* This strengths-based, safety-oriented practice framework guides child protection. Assessment is organised by four domains.²⁴⁶

²⁴¹ University of New England, 2018, *Triage and Assessment Tools: Accessing Help through the Front Door*. Armidale; University of New England.

²⁴² Government of Western Australia Department for Child Protection, 2011, *The Signs of Safety Child Protection Practice Framework*. Perth; Department for Child Protection.

²⁴³ Department for Child Protection and Family Support, 2015, *Western Australian Family and DFV Common Risk Assessment and Risk Management Framework (2nd ed.)*. Perth; Western Australian Government.

²⁴⁴ Department of Health and Human Services, 2016, *Strong Families – Safe Kids: Implementation Plan 2016-2020*. Hobart; State of Tasmania. Department of Health and Human Services, 2016, *Redesign of Child Protection Services Tasmania: 'Strong Families – Safe Kids'*. Hobart; State of Tasmania.

²⁴⁵ Department of Health and Human Services, 2016, *Strong Families – Safe Kids: Implementation Plan 2016-2020*. Hobart; State of Tasmania.

²⁴⁶ Department of Communities, Child Safety and Disability Services, n.d., *Collaborative Assessment and Planning Framework*. Brisbane; State of Queensland. Wise S, 2017, *Developments to strengthen systems for child protection across Australia CFCA Paper No. 44*. Melbourne; AIFS.

- *Victoria: Signs of Safety.* Victoria is planning to introduce Signs of Safety as a tool for assessment.²⁴⁷

Table 9 sets out the most effective tools and instruments to assist and guide professionals in the assessment process. These are used both in Australian and international jurisdictions. They differ in their relative focus on risk, need or strengths and the complexity of the process (for example, the Safeguarding Assessment and Analysis Framework is a seven-stage model whereas Signs of Safety uses three questions).

Table 9 | Assessment tools and frameworks²⁴⁸

Tool	Description	Evidence
Safeguarding Assessment and Analysis Framework	<ul style="list-style-type: none"> • Structured decision-making tool adopted by Children's Services in the UK • Uses a seven-stage model of assessment, analysis and intervention 	This framework appears most effective but formal piloting to test reliability, validity, impact and acceptability is needed.
Signs of Safety	<ul style="list-style-type: none"> • Based on solutions focused brief therapy with three key questions to each assessment: What are we worried about? What is working well? What needs to happen? 	There are many positive elements; however, there is a lack of comparative reviews so a degree of caution is required.
Common Assessment Framework	<ul style="list-style-type: none"> • Focuses on strengths and positive aspects of families • Administered by professionals working across agencies 	Narrative findings indicate difficulties engaging with families.
Family Strengths and Needs Assessment (part of the SDM tools)	<ul style="list-style-type: none"> • Rates factors on a continuum and emphasises dynamic factors; used once assessment has occurred to assist case planning and to engage families 	Found to be somewhat useful in terms of decision-making regarding alternative care arrangements.

4.2.7 Lead professional

This evidence supports key system element 1: Early targeted support, advice and case management. There are additional examples of a lead professional in other sections of this document, including universal home visiting in section 4.2.9 and Sustaining NSW Families and Early Links NSW in section 4.2.10.

The lead professional model refers an individual who is responsible for coordinating the support for a child or family who is in contact with the access system.²⁴⁹ The lead professional typically helps the child or family to navigate the system and connect with the right services to address their needs.²⁵⁰ There are also examples of lead professionals at the universal service level whose main function is to identify children at risk.²⁵¹

Examples and evidence from NSW

The *Independent Review of Out of Home Care in NSW* (2016) (the Tune Review) recommended a key worker or lead professional model in NSW to coordinate support for children and families with complex needs.²⁵² Our summary report identified the following benefits:

- a stronger relationship between the system (lead professional) and a family, based on trust and respect
- earlier identification of the child and family's needs

²⁴⁷ Wise S, 2017, *Developments to strengthen systems for child protection across Australia CFCA Paper No. 44*. Melbourne: AIFS.

²⁴⁸ University of New England, 2018, *Triage and Assessment Tools: Accessing Help through the Front Door*. Armidale; University of New England.

²⁴⁹ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

²⁵⁰ TFM team summary based on research undertaken as part of the high-level design of the Access System.

²⁵¹ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

²⁵² Tune D, 2015, *The Tune Report: Independent review of OOHC*

- assistance in navigation of the system for a family and access to services
- potential avoidance of further trauma as people can avoid retelling their story to multiple services
- progress monitoring of a service/case plan and the ability to adapt it as needed
- coordination of joint responses between agencies and the child and family.²⁵³

The examples of lead professional-type roles in existence across child and family services in NSW below are supported by evidence on effectiveness or impact where it exists:

- **FRS family connectors.** FRS assists children, young people and families who do not meet the statutory threshold for child protection intervention but would benefit from accessing specific services. FRS family connectors conduct a preliminary assessment of families and connect them to services, predominantly through outreach by phone. These services include but are not limited to DFV support (including counselling), housing or accommodation, financial assistance, counselling and mediation, parenting programs, mental health support, and culturally appropriate support services.²⁵⁴ FRS shows early signs of improving effective referrals, access to services, case coordination and collaboration for vulnerable children and families. The flexible and child-focused, family-centred approach and skill set of staff prevented people from falling through the cracks.²⁵⁵ An evaluation of FRS family connectors in schools found that it increased the capacity of schools to handle issues with students who were at risk. It reduced the workload of principals and teaching staff involved with managing and communicating with families who had complex needs and who require higher levels of coordination across multiple services or systems. Parents and students also reported the model as responsive and individualised.²⁵⁶ Additional evidence indicates that early intervention programs in schools can prevent the development of emotional and behavioural difficulties among children and are most effective when they address the needs of the whole family.²⁵⁷
- **Linker role, as part of Ability Links and Early Links.** An evaluation of the Ability Links and Early Links program found the linker role helped to inform people about available services and how to access them. This gave them confidence to seek support, improved their skills and knowledge increased their trust in services. The skills and attributes of people in the linker role were critical.²⁵⁸
- **Nurse home visiting program, as part of Sustaining NSW Families.** This program involves sustained home visits by registered nurses with additional qualifications in child and family health. Nurses use a tiered approach to service delivery, connecting clients to primary health care and more specialised services as needed. An evaluation indicates the program makes a positive difference to the lives of children and their families in terms of their health, safety and developmental outcomes.²⁵⁹

Other examples for which it was not possible to identify evidence on effectiveness included:

- the Linkers Network, as part of a FACS Targeted Earlier Intervention program
- Youth Liaison Officer, School Liaison Police, Multicultural Community Liaison Office, from NSW Police

²⁵³ TFM team summary based on research undertaken as part of the high-level design of the Access System.

²⁵⁴ Unknown author, 2013, *Keep Them Safe Factsheet No.6: FRSs*. s.l.: NSW FACS. NSW Government, n.d., *FRSs*. Retrieved from: http://www.keepthemsafe.nsw.gov.au/initiatives/family_referral_services

²⁵⁵ KPMG, 2013, *Evaluation of FRS*, KPMG. Boston Consulting Group, 2018, *Access Redesign: high level future design and gap analysis*. Unpublished. Parenting Research Centre, 2018, *Access system redesign – a rapid evidence assessment of models of triage and segmentation*. Melbourne: Parenting Research Centre.

²⁵⁶ Hall M. T. and Wurf G, 2016, *An evaluation of the Family Referral Service in schools*. Wagga Wagga, NSW: Research Institute for Professional Practice, Learning and Education, Charles Sturt University.

²⁵⁷ Lane, K. L. and Menzies H. M., 2003, *A school-wide intervention with primary and secondary levels of support for elementary students: Outcomes and considerations*. Education and treatment of Children.

²⁵⁸ Urbis, 2016, *Ability Links NSW Final Evaluation Report 2016*. Sydney: Urbis.

²⁵⁹ KPMG, 2016, *Evaluation of the Sustaining NSW Families Program: Final Report*. NSW Kids and Families.

- Casework Support, as part of the Department of Justice Joint Support Program
- Permanency Coordinator, as part of the FACS Permanent Support Program.²⁶⁰

Examples and evidence from other jurisdictions

There is some evidence from other jurisdictions that the lead professional model has benefits for children and families and supports targeted use of system resources. Examples of models included:

- **Queensland:** Family and Child Connect is a Queensland Government initiative to provide an alternative pathway for families to access services other than a child safety report.²⁶¹ It is a local, community-based service that helps families to care for and protect their children at home, by connecting them to the right services at the right time. Family support workers connect people to services that can improve family relationships, reduce violence at home, and help to manage money, housing, health care and alcohol/drug/gambling problem services. Anyone can refer a family to Family and Child Connect through a hotline, online referral form or at a service location – this includes self-referrals. The service also supports local alliances of government and non-government services to manage system capacity and respond to service gaps in communities. After initial assessment of concern, a range of responses is considered including information and advice; referral to a support service; referral to Intensive Family Support Services; or a report to Child Safety. We did not find evaluations of the effectiveness of this model to date. It was rolled out to 20 locations as at 2016. An assessment of the performance of the child protection system indicated there had been almost 7,000 new referrals to Family and Child Connect services in 2015.²⁶²
- **Australian Capital Territory:** The Strengthening Families pilot project incorporates lead professionals (called lead workers) who work holistically with each family. Lead workers are frontline workers from the government and community sectors who work with and on behalf of families to access services across the Human Services Directorate, including Justice and Community Safety, Community Services, Education and Health. A small-scale evaluation reported that the lead worker provided effective advocacy and mentoring for families and escalated access to services. The evaluation noted that families and lead workers were concerned with how well families could respond to crises independent of the lead worker.²⁶³
- **Scotland:** Lead professionals are involved in cases where complex, inter-agency or specialist support is required or child protection concerns are identified. Lead professionals are typically from a social work background but can come from any agency, including health and education. An evaluation in one local government area identified that lead professionals supported a focused response to children's needs. Lead professionals work closely with the child's 'named person', the designated person assigned to each child from within health or education.²⁶⁴ Every child in Scotland is monitored by a named person (for example, a health visitor or teacher) who constantly assesses a child's wellbeing and identifies when targeted intervention is needed. Families have a named contact that they can go to for advice and support about any aspect of a child's wellbeing. Since implementation of the national framework, *Getting It Right for Every Child* (which includes the named person model), the number of referrals to Children's Reporter decreased by 73 per cent from 2007 to 2017. One challenge is that some people see the model as intrusive and liken it to state surveillance.²⁶⁵

²⁶⁰ TFM, n.d., Lead professional models in NSW. Unpublished.

²⁶¹ Family and Child Connect, n.d., *How we can help*. Retrieved from: <http://familychildconnect.org.au/#others>

²⁶² Queensland Family and Child Commission, 2018, *Annual report*. Brisbane; Queensland Family and Child Commission.

²⁶³ ACT Government, Strengthening Families approach, Retrieved from: <https://www.betterservices.act.gov.au/strengthening-families>

²⁶⁴ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

²⁶⁵ Boston Consulting Group, 2018, *Access Redesign: high level future design and gap analysis*. Unpublished.

- **New Zealand:** This model deploys lead professionals to support children and families in the statutory response pathway. NGOs and government agencies employ lead professionals from diverse backgrounds and professions.²⁶⁶ The lead professional brings together the child, family and community with the practitioners who provide support and services. The lead professional facilitates and monitors the progress of this work. We did not identify any evaluation of the effectiveness of this model.

4.2.8 Differential response

The basic premise of differential response is that families have a range of needs, strengths, capacities and problems, which necessitate an equally wide range of potential intervention strategies.²⁶⁷

A differential response refers to a multi-track system that tailors the response to child protection, based on the identified level of risk.²⁶⁸ In this model, not all cases of child maltreatment follow the traditional investigative (statutory) response pathway. Alternate response pathways are available to families, generally where a lower level of risk is identified. Common features of differential response models include:

- alternative pathways that are needs-focused rather than safety-focused
- access to a broader range of services to prevent the need for statutory intervention
- a collaborative assessment with the family to identify needs, strengths and risks
- voluntary referrals to additional services.²⁶⁹

Examples from NSW or other jurisdictions

Child FIRST and the Integrated Family Services model in Victoria are examples of a differential response model in Australia. An evaluation of both models found that providing a differential response pathway facilitated the appropriate provision of support to address family needs before statutory intervention is required.²⁷⁰

In the United States, differential responses, where reports are assigned either an investigative or an assessment track, is perceived as the most significant change in the country's child protection system in the past two decades.²⁷¹ It was developed as a response to inadequacies of traditional Child Protection Service practice, including the lack of prevention and early intervention services and investigations focused primarily on the 'presenting issue'.²⁷²

Currently, almost half of all states employ some version of differential response; however, there is variability in its implementation. This includes the percentages of reports assigned to the assessment track (between 10-80 per cent) and the availability of services to families in the assessment track.²⁷³

We identified two examples of evaluations of differential response in the United States:

²⁶⁶ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

²⁶⁷ Hughes R, Rycus, J, *Discussion of Issues in Differential Response*. s.l.: Research on Social Work Practice, 23(5), 563-577.

²⁶⁸ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

²⁶⁹ Ibid.

²⁷⁰ Parenting Research Centre, 2018, *Access system redesign – a rapid evidence assessment of models of triage and segmentation*. Melbourne: Parenting Research Centre.

²⁷¹ Wilson, D, 2018, *Effects of Differential Response in Child Protection*. Retrieved from <https://www.uwcita.org/effects-of-differential-response-of-child-protection/>.

²⁷² Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

²⁷³ Wilson, D, 2018, *Effects of Differential Response in Child Protection*. Retrieved from <https://www.uwcita.org/effects-of-differential-response-of-child-protection/>.

- A randomised control trial in Colorado tracked outcomes for families assigned to either a traditional investigation track or a family-needs oriented differential response track. The trial identified no difference in terms of re-involvement with the system. However, cases assigned to the differential response pathway were 18 per cent less likely to have a high-risk assessment. The study also identified that the long-term cost was higher for cases assigned to the investigative track (although there was no initial differences in cost of the two pathways).²⁷⁴
- There was mixed evidence on the success of differential response pathways in Connecticut. One study identified a reduction in children and youth in placement and a smaller number of calls channelled through the traditional investigation route.²⁷⁵ Another study indicated that the differential response was introduced then repealed due to poor implementation.²⁷⁶

A meta-analysis of differential response models in the United States found that:

1. Differential response programs do not adhere to a uniform, standardised practice model, nor are programs implemented consistently across sites.
2. Methodological problems in the differential response research limit confidence in research findings and conclusions.
3. There is insufficient data to confirm the safety of children served in alternative tracks.
4. Differential response programs appear to prioritise allocating services and resources for families in alternative tracks.
5. Differential response literature misrepresents traditional child protective services to enhance an alternative response model.²⁷⁷

Academic commentary highlights the divergence of opinions on differential response and whether it is considered a model, an approach, a method, a philosophy or a practice. Perceived benefits include friendlier investigative practices, greater family engagement and a stronger focus on prevention and early intervention. Evidence shows some promising outcomes for children and families, including lower rates of child placement in OOHC. Perceived limitations include caseworkers using it to reduce workload pressures and the misallocation of resources to low-risk families, where there is little evidence to suggest that most low-risk families progress to higher levels over time. Some argue this divergence of opinion alone is a powerful indication of the further consideration required if differential response is to be fully implemented.²⁷⁸

4.2.9 Universal services

Universal services are available for all children and families in the community. They include essential, basic services and support such as primary health care, school and early childhood education. Universal services work with children and families from an early age and can prevent issues upfront. Families are referred to more specialised services where issues are identified.

Many universal services target early childhood, with programs that support health, and physiological, structural, immune, metabolic and behavioural-response patterns for parents and their children in the first 2000 days of life shown to prevent disease and disadvantage and promote positive outcomes across lifetimes.²⁷⁹

²⁷⁴ Winokur, Ellis, Drury & Rogers, 2015, Referenced in Higgins, D, 2018.

²⁷⁵ Connecticut Department of Children and Families, Internal presentation, 2014, Unpublished.

²⁷⁶ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

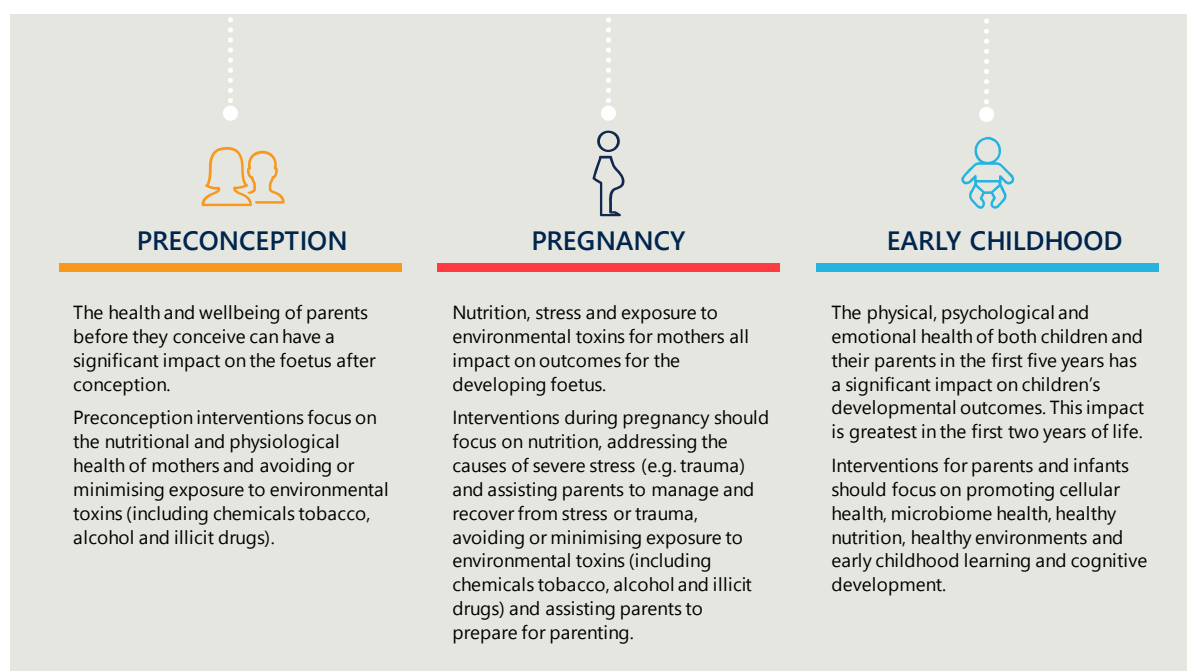
²⁷⁷ Hughes R, Rycus, J, Saunders-Adams, S, Hughes, L, Hughes, K, 2013, *Issues in Differential Response*. Ohio; Research on Social Work Practice.

²⁷⁸ Hughes R, Rycus, J, *Discussion of Issues in Differential Response*. s.l.; Research on Social Work Practice, 23(5), 563-577.

²⁷⁹ Centre for Community Child Health, 2017, *The first thousand days: an evidence paper*. Melbourne: Centre for Community Child Health.

Figure 13 shows the evidence-based, universal early childhood interventions. See in Appendix E for detail.

Figure 13 | Evidence on interventions for preconception, pregnancy and infancy in the first 2000 days²⁸⁰



Examples and evidence from NSW

NSW's universal service stretch across the health, education and family services sectors and include:

- universal home visiting to every parent with a newborn baby
- a quality preschool education program for all four-year-old children
- mental health screening for all mothers in NSW (SAFE START)
- parenting education (Triple P) for all parents with children aged three to eight
- State-wide Aboriginal maternal and infant health services.²⁸¹

Evidence as part of the *Keep them Safe* reforms found that NSW has a strong universal services system and is committed to continuing to strengthen it by increasing the geographic coverage and availability of services to ensure equitable capacity.²⁸²

Universal home visiting to new parents is common and one of the most popular interventions in many jurisdictions.²⁸³ There is some evidence that the visits can have a significant and positive impact on children and mothers. For examples, some programs have been shown to:

- improve women's health related behaviours during pregnancy
- improve children's development status
- reduce the incidence of child abuse and neglect

²⁸⁰ Moore et al., 2017, *The First Thousand Days: An Evidence Paper*. Parkville, Victoria: Centre for Community Child Health.

²⁸¹ NSW Government, 2009, *Keep Them Safe*. s.l.: NSW Department of Premier and Cabinet.

²⁸² NSW Government, 2009, *Keep Them Safe*. s.l.: NSW Department of Premier and Cabinet.

²⁸³ Evaluating Fidelity in Home-Visiting Programs a Qualitative Analysis of 1058 Home Visit Case Notes from 105 Families

- reduce hospital emergency department admissions for injury
- increase mothers' participation in the workforce.²⁸⁴

Features of effective programs include:

- involvement of nurses who start visiting during pregnancy, and visited frequently and long enough to establish a therapeutic alliance with families
- a program design that addresses the behavioural and psychosocial factors that influence maternal and child outcomes
- targeting of families at greater risk for health problems due to parents' poverty and lack of personal and social resources.²⁸⁵

There is limited Australian evidence on the effectiveness of such programs in terms of their impact on early childhood outcomes. The Miller Early Childhood Sustained Home visiting trial was the first Australian study of a sustained home visiting program. It comprised intensive and sustained visits by professionals, commencing pre-birth and running until the child was two for at-risk mothers in disadvantaged communities.²⁸⁶ The target population included low-income families, unmarried mothers or single parents, parents/caregivers with limited education, and families with a history of substance abuse, child abuse or neglect or (current) mental health issues.²⁸⁷ Results from the trial showed improved family functioning, healthier children and more empowered mothers. Specifically:

- New mothers felt more enabled and confident to care for themselves and their child.
- New mothers had significantly better self-rated health.
- Children were breastfed for longer, more engaged with their mother and had improved cognitive development.
- Mothers of infants and toddlers tended to have a better experience of being a mother and provided a home environment that supported their child's development.²⁸⁸

Examples and evidence from other jurisdictions

The types of universal services provided by governments vary considerably across jurisdictions. We identified two alternate international approaches:

- **New Zealand:** The Plunket Nurse home visitation program sees 90 per cent of babies born in New Zealand receive some level of care from Plunket nurses. It is similar to the NSW home visiting program.
- **Sweden:** A public health approach to universal child and family services includes family centres and free preventative care. Sweden has a low zero to 14 years mortality rate which has fallen from 29.96 per 1000 head of population in 2000 to 27.47 in 2012.²⁸⁹

²⁸⁴ Olds DL and Kitzman H, 1990, Can Home Visitation Improve the Health of Women and Children at Environmental Risk? *Journal of Paediatrics* 86(1) 108-116.

²⁸⁵ Ibid.

²⁸⁶ Kemp L, Harris E, McMahan C, Matthey S, Vimpani G anderson T and Schmied V, 2008, *Miller Early Childhood Sustained Home-visiting (MECSH) trial: design, method and sample description*. *BMC Public Health*, 8:424.

²⁸⁷ National Home Visiting Resource Centre, 2016, *Maternal Early Childhood Sustained Home-Visiting*. Retrieved at: <https://www.nhvr.org/wp-content/uploads/DS-MECSH-Profile.pdf>.

²⁸⁸ Early Childhood Connect, 2012, *MECSH Trial Outcomes*. Retrieved at: <https://www.earlychildhoodconnect.edu.au/home-visiting-programs/mecsh-public/mecsh-trial-outcomes>

²⁸⁹ Boston Consulting Group, 2018, *Access Redesign: high level future design and gap analysis*. Unpublished.

4.2.10 Targeted services

Targeted services are enhanced early intervention services that identify and respond to child and family wellbeing issues when they first arise. They typically support children and their families within the community. They maintain child and family wellbeing and aim to prevent the need for children to enter the child protection system.

Examples and evidence from NSW

NSW has several services to support families at low to moderate risk of child wellbeing or child safety issues. At the system-level, evidence shows a continued need to focus efforts and investment on targeted early intervention services, as opposed to statutory responses. Intervening early is more effective at improving child and family outcomes and more cost effective for governments than statutory responses.²⁹⁰

We identified some evidence on the effectiveness of individual early intervention/targeted programs:

- **Brighter Futures** is the largest program within the child and family system in NSW. It is only available for children at ROSH since 2014 but is designed for children at the sub-ROSH threshold as well. It aims to address family vulnerabilities through targeted early intervention services to families with children under nine, or families expecting a child, where the child/children are at a high risk of entering the statutory child protection system. To participate in the program, families must be assessed as requiring casework focused on parental vulnerability, including the presence of DFV. The program includes children's services; parenting programs; structured home visiting programs; and brokerage funded support. Families indicated to a 2010 evaluation that the program had improved family functioning and there was improvement in child behaviour over time. Families dealing with multiple stressors such as low income, poor housing and social isolation were more likely to report no changes in family functioning.²⁹¹ Since 2012, the number of children and families engaged and participating in Brighter Futures with NGOs increased.²⁹²
- **Family Referral Service:** Sub-section 4.2.1 provides evidence on the FRS effectiveness and impact.
- **Sustaining NSW Families:** this program aims to provide long-term health, psychological and social benefits to children, parents and families and the community. It was modelled on evidence-based home visiting program including the Miller Early Childhood Sustain Home visiting trial in NSW. An evaluation indicates that the program makes a positive difference to the lives of children and their families in terms of their health, safety and developmental outcomes. For example, children who participated had higher immunisation rates and breastfeeding levels and scored well on social and emotional development test results.²⁹³
- **Early Links NSW:** Early Links NSW supports parents of children with a disability from birth to age eight. It provides a whole-of-life approach and supports people to overcome practical, emotional and cultural barriers to participation in community life. In the first two years of operation, Early Links NSW has met its objectives, including participants experiencing improved quality of life through links to community and support services, greater contribution to community (for example, running community projects or advising on community groups) and more informed decision-making about decisions that affect their child's future. In addition, the program has reached Aboriginal people with a disability through Aboriginal-specific positions within local Aboriginal community-controlled organisations. Enablers of success for the model included soft entry points, flexible approaches depending on

²⁹⁰ Cassells R et al., 2014, *Keep Them Safe Outcomes Evaluation Final Report*. Sydney: NSW Department of Premier and Cabinet.

²⁹¹ NSW FACS, n.d., *Brighter futures*. Retrieved from: <https://www.facs.nsw.gov.au/families/support-programs/all-families/brighter-futures>

²⁹² Cassells R et al., 2014, *Keep Them Safe Outcomes Evaluation Final Report*. Sydney: NSW Department of Premier and Cabinet.

²⁹³ KPMG, 2015, *Evaluation of the Sustaining NSW Families Program: Final Report*. NSW Kids and Families.

individual needs, strengths-based approach, and a community-driven and culturally appropriate design.²⁹⁴

- **Family case management:** This provides an integrated case management response to support families who are frequently encountered by NSW government agencies and NGOs. The services support families who have shown little improvement in their circumstances, despite considerable input by separate agencies and where there are child wellbeing concerns. We were unable to identify evidence on its effectiveness.
- **SAFE Start:** SAFE Start identifies and supports women and families with a range of social and emotional issues during pregnancy and following birth. It provides psychosocial assessments (including screening for DFV and depression) as a component of routine antenatal and postnatal care. The service also focuses on the mental health and psychosocial issues of fathers and families and to address the relationship between mental health and the parenting role.

Examples and evidence from other jurisdictions

One example of an innovative, wrap-around targeted early intervention service in an international jurisdiction is New York State's Family Assessment Response services, which identify children at-risk early and find solutions to meet the family's needs. It provides an alternative child protection response when there is no immediate danger to children or allegations of serious child abuse.²⁹⁵ Table 10 provides a case study on the Family Assessment Response approach.

Table 10 | New York State targeted early intervention service - Family Assessment Response²⁹⁶

Component	Description
Vision and objective	The objective is to reduce the risk to children by using a family-centred and led approach to engage families in assessing their needs and strengths. The program focuses on solutions to the family's needs rather than on whether there was maltreatment and who is responsible.
Service response	<ul style="list-style-type: none"> • Families are treated as partners and are approached in a non-adversarial way, such as calling parents to arrange a time to meet with family instead of making an unannounced home visit or seeing the children at school without parental knowledge. • The caseworker aims to gain a holistic understanding of the family's functioning through a comprehensive assessment of safety, risk, strengths and needs. There is no formal determination of whether child maltreatment occurred. • Families lead the process of identifying needs and appropriate resources and services, both formal and informal, that they feel will best meet their needs. <p>The program requires:</p> <ul style="list-style-type: none"> • an initial safety assessment to establish the child is safe and to establish ongoing assessments of safety and risk, without an investigation of specific allegations of abuse or maltreatment and no determination of 'indicated' or 'unfounded' • notice to the family of the intent to use the program, rather than a child protection investigation • an examination, with the family, of the family's strengths, concerns and needs • planning and provision of services, including case management where appropriate, that respond to the needs of the family and support family stabilisation.
Enablers	Every worker must meet minimum education and training standards and complete training. A child protection supervisor must review the assessments and decisions made by a worker.
Evidence on effectiveness	In a two-year pilot evaluation in two counties of New York State, children in families assigned to the program were as safe as those children whose families were investigated. Families assigned to the program

²⁹⁴ Urbis, 2016, Ability Links NSW Final Evaluation Report 2016. Sydney: Urbis.

²⁹⁵ Schuyler Centre for Analysis and Advocacy, 2014, *Family Assessment Response Fact Sheet*. Albany, New York: Schuyler Centre.

²⁹⁶ Schuyler Centre for Analysis and Advocacy, 2014, *Family Assessment Response Fact Sheet*. Albany, New York: Schuyler Centre.

were less likely to have a petition filed in family court. There was some evidence that the program can reduce placements in foster care.

Leveraging the evidence on what works for Aboriginal families and communities



At the service delivery level, it is important to ensure that children and families in contact with the child and family system are supported to maintain contact with their families and cultural community. This will satisfy their basic human rights and contribute to identity formation and lifelong support. Knowledge of family story was found to be a major factor in predicting strength of connection to culture, as was support from carers and frequency of contact with their father.

An evaluation of a pilot program that involved Aboriginal people in design and delivery of a child and family service provides some learnings to inform the Access System Review. The evaluation identified the following success factors:

- a clear, long-term commitment to a partnership approach from senior management
- a core group of staff that are involved in the long-term
- a clear purpose and vision for the service in terms of supporting local Aboriginal peoples' needs
- mechanisms that enable Aboriginal perspectives to inform policy, planning and delivery decisions
- documented and broadly understood information sharing processes
- accountable, responsive and inclusive decision-making.

4.3 Enablers

Enablers are supporting structures or functions that enable specific system functions. This section covers:

- **Governance** – including accountability and a single planning framework
- **Funding** – including funding mechanisms and the investment and commissioning approach
- **Information and data collection and sharing** – including legislation and data analytics
- **Technology** – including the information and communication technology policies and practices
- **Workforce** – including capacity, capability and culture
- **Performance monitoring and evaluation** – including a system-level evaluation framework.

4.3.1 Governance

Governance and accountability

Research undertaken by Ernst and Young provided evidence-based recommendations for system-level governance and management of the access system:

- development of a system-wide, person-centred outcomes framework with agreed outcomes, indicators and measures by which agencies and service providers can meaningfully measure results and use these to drive quality assurance/continuous service improvement.
- governance structures within each agency that clearly set out and embed accountability, roles and responsibilities for achieving agreed system-wide objectives.²⁹⁷

²⁹⁷ Ernst and Young, 2018, *User segmentation – reference group presentation*. Unpublished.

Evidence on best-practice approaches to system-level governance for an integrated health care system provides relevant learnings for the Access System Redesign, including:

- **Governance:** Governance structures should increase transparency of decision making, policy and service planning. There should be direct engagement with communities, so the system is tailored to the needs of communities. Evidence from Queensland, New Zealand, Scotland, Wales and The Netherlands indicates this is fundamental to improving system integration and care delivery.²⁹⁸
- **Accountability:** Evidence-based, outcomes-focused and consumer-centric measures of success should consider whether people receive the services they need, whether providers are working in a team and communicate, whether people are involved in their own supports and whether funding is flexible.²⁹⁹

There are some learnings for the NSW context based on work to reform governance approaches for the child wellbeing system in Tasmania. The *Strong Families, Safe Kids Implementation Plan* identified success factors for effective governance, shown in Figure 14.

Figure 14 | Examples of success factors for effective system governance³⁰⁰



In addition, the Tasmanian Department of Health and Human Services is planning to implement a cross-sectoral Child Wellbeing Consultative Committee to provide input into the delivery of *Strong Families, Safe Kids*.³⁰¹ There will also be a high-level Child Protection Redesign Oversight Committee with membership including heads of all relevant agencies to ensure accountability for reform implementation.³⁰²

Single planning framework

A single, whole-of-government planning framework can reduce duplication across the system, decrease the need for families to repeat their story and support multi-agency collaborative work.³⁰³ Examples from other jurisdictions include:

- **Tasmania.** Under the single framework in development, the Tasmanian Government will require all government services to share information and planning documents for vulnerable children identified through the state-wide Common Risk Assessment Framework. These documents be held in a single repository, to be used in further case coordination and intervention planning. Information sharing will be a fundamental guiding principle, with all the necessary safeguards used to protect confidential information (as defined by legislation) and privacy considerations.³⁰⁴
- **South Australia.** The Family Safety Framework aims to drive integrated service responses to violence against women and children. It is used by police, health, housing and corrections. It outlines multiple

²⁹⁸ Nous Group, 2017, *Integrated health care: Literature review*. Prepared for the NSW Ministry of Health.

²⁹⁹ Nous Group, 2017, *Integrated health care: consultation paper*. Prepared for the NSW Ministry of Health.

³⁰⁰ Department of Health and Human Services, 2016, *Strong Families – Safe Kids: Implementation Plan 2016-2020*. Hobart: State of Tasmania.

³⁰¹ Ibid.

³⁰² Department of Health and Human Services, 2016, *Strong Families – Safe Kids: Implementation Plan 2016-2020*. Hobart: State of Tasmania.

³⁰³ Ibid.

³⁰⁴ Ibid.

entry points available to families through any Family Safety Framework agencies. While it is not possible to determine the effectiveness of this model, initial trials suggest that responses to victims of DFV were timelier and better coordinated. Information sharing protocols and agreements worked better through the framework, facilitating interagency collaboration.³⁰⁵

Table 11 summarises approaches from selected international jurisdictions. Limited evidence was available on the impact or effectiveness of these planning frameworks.

Table 11 | Single planning frameworks implemented or planned in other jurisdictions³⁰⁶

Jurisdiction	Description and evidence on effectiveness (if available)
Sweden, <i>Barns behov i centrum</i> (BBIC) Framework³⁰⁷	The BBIC is a framework for the assessment, planning and review of child wellbeing and welfare in Sweden. It provides a structure for the systematic collection of information and documentation of service needs for individuals. Pilots of BBIC showed that the system had a greater focus on the child than prior to framework implementation and more effective assessments, though at the expense of increased administration. The framework has seen an increase of documented contacts between social workers and relevant agencies.
Scotland, <i>Getting It Right for Every Child</i>	<i>Getting It Right for Every Child</i> is the Scottish Government's approach and national framework for child protection. An evaluation of a pilot project five years after its implementation in 2008 showed: <ul style="list-style-type: none"> • higher numbers of interventions and supports being used (but for shorter periods) • less children re-offending and numbers of school expulsions.

³⁰⁵ Boston Consulting Group, 2018, *Access Redesign: high level future design and gap analysis*. Unpublished.

³⁰⁶ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

³⁰⁷ Socialstyrelsen and BBIC, n.d., *Child welfare in a state of change – final report from the BBIC project*. s.l.: Socialstyrelsen.



Effective governance for Aboriginal child and family systems

Evidence tells us that several features will underpin effective governance of Aboriginal-led and local community responses in the Aboriginal child and family system:

- **Aboriginal self-determination in decision making.** This includes empowering families and communities to be involved in decision-making and have greater responsibility around the safety and wellbeing of children – particularly important for Aboriginal families where child protection and child safety responses are needed. NSW is reviewing legislative options that may be applicable here; for example, Victoria requires Aboriginal decision-maker participation in decisions about child protection reports.
- **Localised and shared decision-making.** This includes genuine engagement with local communities on how best to meet the needs of Aboriginal children and families, particularly those impacted by child protection. It should be based on a transparent and agreed understanding of local resources and community strengths.^{308,309}
- **Partnerships.** This refers to partnerships between Aboriginal people and all levels of governance in the system.
- **Balanced approaches.** This could include a balance between bottom-up and top-down approaches and between forensic, healing and community-building services.³¹⁰

An AbSec study identified several barriers to improving Aboriginal governance structures: distrust within communities, tokenistic inclusion within non-Aboriginal governance structures and ongoing structural racism and paternalism that assumes that Aboriginal communities are unwilling or unable to make sound decisions in addressing the challenges they face.^{311,312}

To help address these barriers, AbSec have developed a proposed planning framework for Aboriginal child and family services – *Our kids, Our families, Our Way*. It empowers local communities and Aboriginal community-controlled organisations to develop and adapt responses based on:

- available evidence
- practitioner experience
- community values.³¹³

4.3.2 Funding

NSW is developing a new strategic commissioning framework to provide a consistent model for policy, planning, service design, procurement and monitoring. It will aim to articulate the end-to-end business processes, their linkages and accountabilities. Outcomes monitoring will be central.³¹⁴

Several evidence-based reforms for the funding approach and mechanisms for the child and family system have been suggested in recent reviews. The Tune Review outlined the elements of a best-practice funding and investment approach for the broader child and family system, which provides learning for the Access System Redesign:

- *An outcomes framework:* a whole-of-government outcomes framework that reinforces shared accountability for outcomes across agencies and provides a set of quantifiable measures of client success.

³⁰⁸ AbSec, 2016, *Achieving a holistic Aboriginal Child and Family Service System for NSW*. Sydney: AbSec.

³⁰⁹ AbSec, 2018, *An Aboriginal commissioning approach to Aboriginal Child and Family Services in NSW: A conceptual design*. Sydney: AbSec.

³¹⁰ <https://www.tandfonline.com/doi/abs/10.1080/03124071003717663>

³¹¹ AbSec, 2016, *Achieving a holistic Aboriginal Child and Family Service System for NSW*. Sydney: AbSec.

³¹² AbSec, 2018, *An Aboriginal commissioning approach to Aboriginal Child and Family Services in NSW: A conceptual design*. Sydney: AbSec.

³¹³ AbSec, n.d., *'Our kids, our families, our way': Strengthening Aboriginal Families so their children can thrive*. Unpublished

³¹⁴ As reported by the TFM project team.

- *A vulnerable families dataset*: a single dataset to capture and analyse data across policy areas to support evidence-based funding decisions.
- *Decision-making and accountability structures*: clear structures to enable and monitor system change and implementation of new solutions and ensure cross-agency accountability in funding decisions.
- *Reporting and reallocation cycle*: a cyclical monitoring and review environment to provide regular, coordinated monitoring and reporting to ensure that resource allocation is based on evidence.³¹⁵

The Tune Review also recommended the establishment of a NSW Family Investment Commission as a statutory authority within the FACS cluster that would:

- identify cross-agency funds that it would appropriate for vulnerable children and families across many sections (social housing, mental health DFV, drug and alcohol misuse, targeted early intervention, justice and education) as the basis of personalised support packages for vulnerable children or parental support
- hold the budget for vulnerable children and families in one place (including the child protection, OOHC and *Keep Them Safe* budgets)
- prioritise cohorts and provide parameters for local commissioning of interventions
- use a transparent and flexible funding allocation.³¹⁶

Previous work to strengthen the approach to integrated healthcare in NSW that aligns with the Tune Review will also inform the Access System Redesign. In this work, NSW stakeholders identified that restrictive and inflexible funding practices are a barrier to integrated health care.³¹⁷ This includes funding siloed to the health and social care systems that does not provide the flexibility or financial levers to develop locally designed systems.

Examples of international funding approaches to support integrated care include:

- pay-for-coordination to reward the coordination of MDTs and pay-for-performance to reward improvements in the process and outcomes of care
- bundled payments for a group of specific services that involve multiple providers
- investments in data and analytics, including data linkage is important to sustain delivery of care that is integrated
- creation and continued investment in an integrated care fund to shift the balance of care towards prevention and support services that deliver outcomes for local communities (Scotland).³¹⁸

We did not identify evidence on the effectiveness of the above funding and investment mechanisms.

³¹⁵ Tune D, 2015, *The Tune Report: Independent review of OOHC. Appendix 2.*

³¹⁶ Tune D, 2015, *The Tune Report: Independent review of OOHC.*

³¹⁷ Nous Group, 2017, *Integrated health care: Literature review.* Prepared for the NSW Ministry of Health.

³¹⁸ Ham C, Heenan D, Longley M and Steel DR, 2013, *Integrated care in Northern Ireland, Scotland and Wales: Lessons for England, The King's Fund.* London: The Kings Fund.



Flexible funding guided by an Aboriginal-led outcomes framework will enable a more flexible, tailored Aboriginal-led service system.³¹⁹ AbSec has proposed an Aboriginal commissioning model to enable a holistic, culturally relevant Aboriginal child and family service system – one that is designed and led by local Aboriginal community organisations. Recommendations from recent child protection parliamentary reviews support AbSec's work. Key themes related to funding included:

- funding for Aboriginal-led services that is focused on outputs rather than outcomes
- more flexible funding guidelines that recognise the nuances of service delivery in Aboriginal communities and allow for flexibility in service responses and locally determined outcome measures
- increased funding specifically for Aboriginal-led responses, recognising the chronic underfunding of culturally embedded services for Aboriginal children and families.³²⁰

4.3.3 Information and data collection and sharing

There is no streamlined, system-wide approach for data collection and information sharing across the statutory and/non-statutory pathways in NSW. No single mechanism enables effective data and information sharing between agencies and/or service providers.

The Tune Review provided some recommendations on ways NSW can improve the evidence base to inform policy and planning decisions and support greater information sharing:

- develop a **cross-agency data set** in partnership with the Data Analytics Centre as a single point to collect data from across the child and family system
- engage the **Data Analytics Centre** as the central owner and manager of a cross-agency data set
- increase **data analysis to inform decisions**, including development of a baseline to inform policy, planning and investment decisions and analysis on system-wide service usage and client journeys. This would require data on client level service usage across NSW and Commonwealth government agencies, some Commonwealth medical usage data, NGO service usage data, program level outcome measures, intervention cost/unit cost data and others to establish client and cohort level outcomes.³²¹

Table 12 summarises approaches and reforms in other jurisdictions. Key themes relate to increased investment in data analytics and improving the enabling legislation to support information sharing.³²² There was limited or no evidence available on the effectiveness of these reforms.




³¹⁹ AbSec, 2016, *Achieving a holistic Aboriginal Child and Family Service System for NSW*. Sydney: AbSec.

³²⁰ AbSec, 2018, *An Aboriginal commissioning approach to Aboriginal Child and Family Services in NSW: A conceptual design*. Sydney: AbSec.

³²¹ Tune D, 2015, *The Tune Report: Independent review of OOHHC*. Appendix 2.

³²² Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

Table 12 | Selected approaches and reforms to improve data collection and information sharing³²³

Jurisdiction	Approach or reforms related to data collection and information sharing
 South Australia	<ul style="list-style-type: none"> • <i>Data analysis:</i> South Australia is investing in data analytics and examining risk factors. In meeting one of the major recommendations from the Child Protection Systems Royal Commission, the South Australian Government has established the Early Intervention Research Directorate, which will create a five-year prevention and early intervention strategy for children and families. The directorate will handle the Government's data, evaluation, research and practice functions and work collaboratively with the academic sector to develop primary and secondary interventions. The directorate focuses on Aboriginal children and young people. It uses a centralised service system, electronic management system and robust information sharing protocols to ensure effective data and information collection, analysis and evidence-based decisions.³²⁴
 Queensland	<ul style="list-style-type: none"> • <i>Legislation:</i> Revised legislation will support the new Family and Child Connect model (<i>Child Protection Reform Amendment Act 2017</i>). Queensland has also consolidated all reporting obligations into the <i>Child Protection Act 1999</i>. A review of the <i>Child Protection Act 1999</i> aims to ensure the support system is underpinned by contemporary legislative framework. Queensland has also replaced the Police Service policy for mandatory reporting of DFV to Child Safety with a standard child harm referral framework. This better aligns with community-based intake and referral processes. • <i>Information sharing:</i> Legislation introduced in October 2018 aims to address barriers to information sharing within and across government and non-government agencies.
 Scotland	<ul style="list-style-type: none"> • <i>Legislation:</i> Scotland has introduced legislative changes for information sharing. The Child and Young People (Information Sharing) Bill was introduced in 2017 requires consideration if the sharing of the information will promote child wellbeing. • <i>Information sharing:</i> There is reportedly strong coordination between different agencies in the social work, education, health and police sectors that supports effective information sharing.
 Tasmania ³²⁵	<ul style="list-style-type: none"> • <i>Information sharing:</i> The Advice and Referral Service (intake service) will be co-located with Safe Families Tasmania (a cross-agency initiative under the Tasmanian Government's Family Violence Action Plan). This will use and improve the existing processes for information gathering to share and access information from multiple government databases.
 Ontario	<ul style="list-style-type: none"> • <i>Legislation:</i> In April 2018, the Child, Youth and Family Services Act was introduced, which supports the transformation to improve the experience for children, youth and their families. Key changes include placing youth and children at the centre of decision-making, improving the oversight of residential services and focusing on early intervention and prevention. It also allows First Nations people to be exempt from any provision of the Child, Youth and Family Services Act. This allows First Nations child welfare agencies to develop more culturally appropriate services. • <i>Data collection:</i> Triage and assessment systems are codified within the Ontario Child Protection Standards and Ontario Child Protection Tools Manual.
 NZ	<ul style="list-style-type: none"> • <i>Information sharing:</i> A suite of reforms helps government agencies to better share information. Legislation to create an information sharing framework provides guidance for organisations and professionals to share information if they have child safety concerns. Key features include proactive information sharing, information sharing in good faith and provisions for the Ministry for Vulnerable Children to require information sharing.³²⁶

Evidence on overlapping systems and responses

What can the Access System Redesign learn from efforts to integrate health services?

³²³ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

³²⁴ SA Department of Child Protection, 2018, *Early Intervention Research Directorate*. Retrieved from: <https://www.childprotection.sa.gov.au/department/fresh-start/early-intervention-research-directorate-eird>

³²⁵ Department of Health and Human Services, 2016, *Strong Families – Safe Kids: Implementation Plan 2016-2020*. Hobart: State of Tasmania.

³²⁶ NZ Family Violence Clearinghouse, 2016, *Government announces information sharing framework*. Retrieved from: <https://nzfvc.org.nz/news/government-announces-information-sharing-framework>

Research and initiatives in NSW and other jurisdictions aim to support an integrated approach to health care. A literature review prepared for NSW Health examined the success factors critical to the integration of health care – many of which are translatable when considering how to better integrate child and family services and/or other social services. These include:


- reorganise governance structures to increase transparency and engagement with the community
- establish ongoing review and evaluation mechanisms over the short, medium and long-term
- establish health and social care system and structural arrangements to regulate and sustain integration of care initiatives
- develop a change management approach to streamline systems transformation
- use funding to stimulate immediate and long-term improvements in performance and to remove financial barriers
- provide training in performance management of health services
- establish informal behaviour codes and develop professional ethical standards
- ensure a common purpose and motivation through common language, shared vision and channels of communication
- encourage practitioners to think from a person-centred approach and provide adequate professional development
- establish both clinical and non-clinical administrative processes and workflows to increase efficiency
- utilise integrated information technology structures to share information
- extend integrated information technology structures to link with back-end processes.³²⁷

4.3.4 Technology

The benefits of technology to a child and family system include timely availability and retrieval of information; standardisation and protection of sensitive information; and a greater ability for agencies to be more accountable. However, poorly designed technology and implementation can lead to the loss of human interaction in the case management process; issues with interagency and system interoperability; data sharing and data privacy; and limited capacity to ensure proper use and comfort with technology for the workforce.³²⁸

Examples of technologies in child protection include interagency data-sharing and data-integration systems, cloud-based information systems and social media platforms.³²⁹ An area of rapid innovation and new applications is the use of mobile technologies – smartphones, tablets and laptops – to gather and transmit data.³³⁰ Some mobile devices have been rolled out in FACS over the last few years as part of the ChildStory system. Mobile devices have the potential to provide real-time, secure access to information for child welfare workers and their clients.³³¹ Table 13 summarises the use of mobile technologies in other jurisdictions.

Table 13 | Use of mobile technologies in Australian and international jurisdictions

Jurisdiction	Use of mobile technologies
 Indiana	Indiana implemented a cloud-based, fully mobile child welfare information system and case management platform in 2012 that allows workers to see information in real time and allows multiple providers to submit



³²⁷ Nous Group, 2017, *Integrated health care: Literature review*. Prepared for the NSW Ministry of Health.

³²⁸ Krauter C, 2017, *Child Protection Case Management*. Retrieved from <https://datanova.com.au/child-protection-case-management/>. Kaonga N, Batavia H, Philbrick W, Mechael P, 2016, *Information and Communication Technology for Child Protection Case Management in Emergencies: An Overview of the Existing Evidence Base*. Massachusetts; Procedia Engineering 159, 112-117, Smith R, Eaton T, 2014, *Information and Communication Technology in Child Welfare: The Need for Culture-Centered Computing*. Western Michigan; The Journal of Sociology & Social Welfare, 41(1).

³²⁹ Hughes K, 2018, *Research Summary: Innovative Technologies in Child Welfare Services*. San Diego State; The Academy for Professional Excellence.

³³⁰ Mattila M, 2011, *Mobile Technologies for Child Protection*. Dakar; UNICEF.

³³¹ Smith R, Eaton T, 2014, *Information and Communication Technology in Child Welfare: The Need for Culture-Centered Computing*. Western Michigan; The Journal of Sociology & Social Welfare, 41(1).

 <p>Arizona</p>  <p>Tasmania³³⁴</p>	<p>information. Embedding and prominently displaying a face-to-face contact metric resulted in a 13.8 per cent increase in face-to-face contacts over a 30-day period.³³²</p> <p>Using mobile devices, caseworkers can receive and deliver real-time data anywhere and anytime through a government cloud-based, secure and reliable platform. Mobile technology allows workers to engage more productively with children and families so they can devote more time to children and families rather than paperwork. Arizona is projected to save \$18.7 million annually, has increased field access to the information system to 100 per cent, improved caseworker efficiency by 20 per cent, increased caseworker time spent with children and families and enhanced service quality and case outcomes.³³³</p> <p>As part of the <i>Strong Families, Safe Kids</i> initiative, the Department of Health and Human Services will invest in mobile computing and other flexible technology options to support integrated and mobile case recording by frontline staff. The Tasmanian Government committed to expanding the existing KIDZ data warehouse to support professional, evidence-based decision-making.³³⁵</p>
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Any development and implementation of new technologies as part of the Access System Redesign should:

- **Involve users.** An evaluation of the Californian Needs Portal found that the needs of children, young people and families were better met when users were active participants in the implementation and refinement of the new technology³³⁶
- **Promote innovation.** In 2016, the United States Department for Children and Families issued the *Comprehensive Child Welfare Information System final rule* which removed the requirement for a single comprehensive system. This promoted innovation and agility in technology by allowing agencies the flexibility to build systems tailored to their unique needs³³⁷
- **Build in child-friendliness.** This ensures that technology does not amplify existing vulnerabilities or otherwise cause further harm to the child.³³⁸ Greater research is needed as to whether technology is able to enable more child-friendly method of managing information.³³⁹

4.3.5 Workforce

Note: This evidence supports key system element 8: Awareness and capability development.

A highly skilled, capable and supported workforce across government and non-government sectors is essential. NSW's diverse child and family services workforce includes employees in FACS, NSW Health, the Department of Education and the Justice cluster. A significant proportion of the workforce sits within State-wide and local NGOs that deliver critical services such as early intervention, placement prevention and restoration services. Children and families with complex needs are likely to interact with multiple sectors of the workforce across many different agencies.³⁴⁰

Figure 15 indicates the Australian child protection workforce is majority female, generally young, predominantly Australian born, but with higher proportions of Aboriginal people than the general population.

³³² Hughes K, 2018, *Research Summary: Innovative Technologies in Child Welfare Services*. San Diego State; The Academy for Professional Excellence.

³³³ Ibid.

³³⁴ Department of Health and Human Services, 2016, *Strong Families – Safe Kids: Implementation Plan 2016-2020*. Hobart: State of Tasmania.

³³⁵ Ibid.

³³⁶ Dellor E, Lovato-Hermann K, Wolf J, Curry S, Freisthler B, 2015, *Introducing Technology in Child Welfare Referrals: A Case Study*. s.l.; Journal of Technology in Human Services, 33(4).

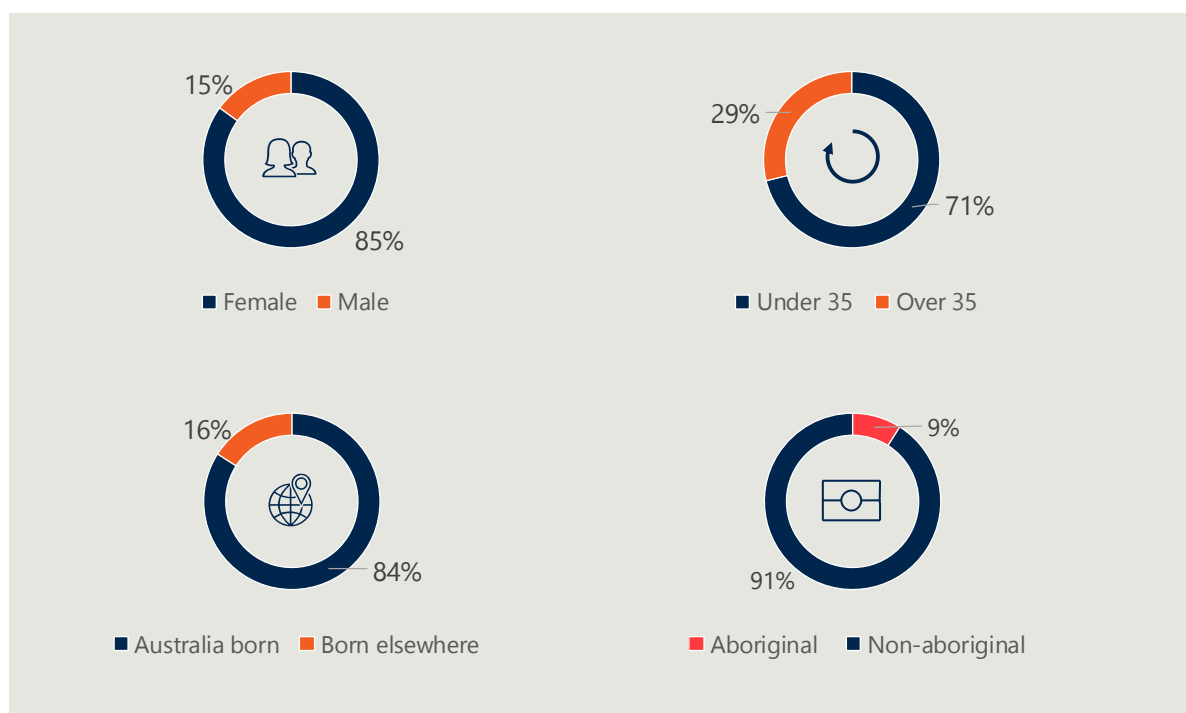
³³⁷ Hughes K, 2018, *Research Summary: Innovative Technologies in Child Welfare Services*. San Diego State; The Academy for Professional Excellence.

³³⁸ Krauter C, 2017, *Child Protection Case Management*. Retrieved from <https://datanova.com.au/child-protection-case-management/>. Kaonga N, Batavia H, Philbrick W, Mechael P, 2016, *Information and Communication Technology for Child Protection Case Management in Emergencies: An Overview of the Existing Evidence Base*. Massachusetts; Procedia Engineering 159, 112-117.

³³⁹ Krauter C, 2017, *Child Protection Case Management*. Retrieved from <https://datanova.com.au/child-protection-case-management/>.

³⁴⁰ Tune D, 2015, *The Tune Report: Independent review of OOH*

Figure 15 | Profile of Australian child protection workers³⁴¹



Challenges to attracting, recruiting and retaining child and family services workers include:

- a lack of social workers graduating who are considering child protection as a career
- difficult recruiting in regional and remote areas and recruiting Aboriginal staff
- high levels of stress, emotional distress and secondary trauma
- unreasonable workloads and burnout
- negative public perception of child protection work
- poor organisational culture and support
- low cultural competency of workforce
- larger drivers including economic conditions, competition for workers with other government departments, changing and unpredictable demand for child protection services and restructuring of departments.^{342,343}

³⁴¹ Martin B, Healy J, 2010, *Who works in Community Services? A profile of Australian workforces in child protection, juvenile justice, disability services and general community services*. Adelaide; National Institute of Labour Studies. McArthur M, Thomson L, 2012, *National analysis of the workforce trends in statutory child protection*. Canberra; Institute of Child Protection Studies.

³⁴² Lewig K, McLean S, 2016, *Caring for our frontline child protection workforce*. s.l.; Child Family Community Australia. McArthur M, Thomson L 2012, *National analysis of the workforce trends in statutory child protection*; McArthur M, Thomson L 2012, *National analysis of the workforce trends in statutory child protection*; Department of Health and Human Services, 2018, *Child protection workforce strategy 2017-2020*. Melbourne; State of Victoria. Baltruks D, Hussein S, Montero L, 2017, *Investing in the social services workforce*. Brighton; European Social Network. McArthur M, Braithwaite V, Winkworth G, Wilson F, Conroy S, Thomson B, Ivec M, Harris N, Reinhart M, *How Relevant is the Role of Values in Child Protection Practice? A National Survey of Statutory Child Protection Staff 2009*. Canberra; Regulatory Institutions Network. Kaur J, 2012, 'Cultural Competence in Child Protection' & the needs of Culturally and Linguistically Diverse children and families who come to the attention of the Queensland Child Protection System. s.l.; JK Diversity Consultants. McFadden P, 2015, *Professional Resilience: The Relational Spiral in the Child Protection Workforce*. Belfast; Queen's University. Victorian Auditor-General's Office, 2018, *Maintaining the Mental Health of Child Protection Practitioners*. s.l.; Victorian Government.

³⁴³ McArthur M, Thomson L 2012, *National analysis of the workforce trends in statutory child protection*

The evidence tell us that a strong, skilled, healthy and sustainable workforce requires:³⁴⁴

- **Ongoing training and professional development opportunities.** For example, in the *Strong Families, Safe Kids Implementation Plan*, the Tasmanian Government committed additional resources for professional development.³⁴⁵
- **A well-promoted child protection profession.** For example, Victoria's *Child Protection Workforce Strategy 2017-2020* emphasises formally establishing a child protection profession to promote high professional expectations and raise the standing of child protection work in the community.³⁴⁶
- **Constructive workplace culture.** For example, the *Fish! Philosophy* in Joondalup District, Western Australia encompasses monthly staff activities on the concepts of attitude, presence, thinking of others and having fun. The activities increase the sense of collegiality, reward staff who demonstrate the Fish! Philosophy and increase the sense of belonging.³⁴⁷

Other elements include remuneration and working conditions; opportunities for career progression; sustainable workloads; psychological safety initiatives; and opportunities for cross-agency collaboration and knowledge sharing.³⁴⁸

The Tune Review also made workforce recommendations:

- **Introduce a key worker model** to provide a single point of contact for children and families accessing services across multiple agencies (evidence on the effectiveness of key worker coordination models is explored in section 4.2.7).
- **Clarify roles and responsibilities** of the Department of Education, NSW Health and FACS when assessing and responding to child protection and wellbeing concerns.
- **Build the capacity and readiness of the workforce** to tailor support for children and families.
- **Improve the cultural competency of staff** to ensure effective engagement with and service delivery for Aboriginal families (see more detail overleaf).³⁴⁹

Leveraging the evidence on what works for Aboriginal families and communities



We have identified similar themes in available evidence on what an effective workforce looks like for supporting Aboriginal children and families. Important recommendations from AbSec's blueprint for a NSW Aboriginal child and family service system to consider in the Access System Redesign include:

- Aboriginal community-controlled organisations are best placed to deliver services and achieve outcomes for Aboriginal children and families.
- There should be a focus on enhancing the capacity of existing Aboriginal community-controlled organisations.
- There should be ongoing learning and development for the workforce and those who provide support to children and families.³⁵⁰

³⁴⁴ Lewig K, McLean S, 2016, *Caring for our frontline child protection workforce*. s.l.; Child Family Community Australia. Baltruks D, Hussein S, Montero L, 2017, *Investing in the social services workforce*. Brighton; European Social Network. McArthur M, Thomson L, 2012, *National analysis of the workforce trends in statutory child protection*. Canberra; Institute of Child Protection Studies. Tune D, 2015, *The Tune Report: Independent review of OOHC*.

³⁴⁵ Department of Health and Human Services, 2016, *Strong Families – Safe Kids: Implementation Plan 2016-2020*. Hobart; State of Tasmania.

³⁴⁶ Department of Health and Human Services, 2018, *Child protection workforce strategy 2017-2020*. Melbourne; State of Victoria.

³⁴⁷ Department for Child Protection, 2010, *People Development Framework 2010-2012*. s.l.; Government for Western Australia.

³⁴⁸ Lewig K, McLean S, 2016, *Caring for our frontline child protection workforce*. s.l.; Child Family Community Australia. Baltruks D, Hussein S, Montero L, 2017, *Investing in the social services workforce*. Brighton; European Social Network. McArthur M, Thomson L, 2012, *National analysis of the workforce trends in statutory child protection*. Canberra; Institute of Child Protection Studies. Tune D, 2015, *The Tune Report: Independent review of OOHC*.

³⁴⁹ Tune D, 2015, *The Tune Report: Independent review of OOHC*.

³⁵⁰ AbSec, 2016, *Achieving a holistic Aboriginal Child and Family Service System for NSW*. Sydney: AbSec.

The NSW Aboriginal Child and Family Industry Development Strategy sets out initiatives to workforce capabilities and promote employment opportunities in the sector:

- increase capacity to engage with the sector and understand the needs of different communities to support locally directed services planning
- develop a sector-wide workforce development strategy and align it to whole-of-government plans
- support Aboriginal community-controlled organisations to develop locally directed workforce plans that contribute to a state-wide workforce strategy
- improve coordination of and access to existing training and identify areas for new training.³⁵¹

NSW can also learn from recent reforms in Western Australia, where recommendations to improve the cultural competence of the Western Australia child protection workforce included:³⁵²

- develop and implement a strategy to support the expansion of the Aboriginal community-controlled organisation sector that will enable it to deliver significant proportions of family support services
- develop and implement a five-year Workforce Development Plan that includes a cultural leadership and a cultural supervision program for both Aboriginal and non-Aboriginal employees; reviewing and setting targets for Aboriginal workforce development, including recruiting and retaining Aboriginal staff; and increasing the cultural competence of all staff to work with Aboriginal children and families
- implement overarching service standards for all Department-funded family support services to demonstrate culturally competent services to Aboriginal children and families.

Other evidence on what will improve cultural competency of the Australian child protection workforce that should inform the Access System Redesign includes:

- recruit and retain culturally diverse child protection workforce and bicultural staff
- develop interpreter guidelines and training on the use of interpreters for frontline child protection practitioners
- develop cross-cultural competency training specific to child protection
- use recruitment strategies for foster and kinship carers from culturally and linguistically diverse backgrounds
- develop practice guidelines for working with culturally and linguistically diverse families
- develop cultural support plans for culturally and linguistically diverse children and young people placed in OOHC.³⁵³

4.3.6 Performance monitoring and evaluation

This evidence supports key system element 6: Monitoring and Outcomes Framework for continuous improvement.

Performance monitoring and evaluation enables the collection and use of accurate and regular data on system effectiveness to advocate for and enact improvements where required.³⁵⁴

UNICEF's key elements of a child protection monitoring system should be considered as part of the Access System Redesign. They are:

- a logical framework with a clear chain of results, including desired impact, outcomes and outputs; a budget; and indicators to track progress

³⁵¹ Aboriginal Child, Family and Community Care Secretariat, NSW Department of Family and Community Services, n.d., *NSW Aboriginal Child and Family Industry Development Strategy*. s.l.; NSW Government.

³⁵² Department of Child Protection and Family Support, 2016, *Building Safe and strong Families: Earlier Intervention and Family Support Strategy*. s.l.; Government of Western Australia.

³⁵³ Network. Kaur J, 2012, 'Cultural Competence in Child Protection' & the needs of Culturally and Linguistically Diverse children and families who come to the attention of the Queensland Child Protection System. s.l.; JK Diversity Consultants.

³⁵⁴ United Nations Children's Fund, 2012, *Measuring and Monitoring Child Protection Systems: Proposed Core Indicators for the East Asia and Pacific Region*. Bangkok; UNICEF.

- agreement on the required capacities for monitoring and evaluating a child protection program as well as an estimated budget for monitoring and evaluation.³⁵⁵

NSW does not have a comprehensive, State-wide framework to assess and evaluate the performance of the access system and services. The Tune Review noted that system user outcomes are rarely monitored or measured, which makes it difficult to assess the effectiveness of interventions for children and families or make targeted investments to what works best for different groups.³⁵⁶ It recommended a cross-government outcomes framework, building on the Human Services Outcomes Framework.³⁵⁷ We have had regard to the Tune Review recommendations and the evidence supports the following to improve performance monitoring:

- make evaluation and performance management tools across the system consistent with the outcomes framework, with a feedback loop between system-level and operational tools
- consistently management performance to link monitoring at the individual, service, cohort and whole of population/policy level through the common outcomes framework
- take a centralised view of need and vulnerability across the population to understand the need for intervention and provide a base level against which to measure outcomes
- use a test and learn approach to test the effectiveness of services for different populations and understand interim outcomes
- monitor services for actual performance against expected performance to guide the deployment of services toward more effective outcomes.³⁵⁸

A system-level outcome framework articulates a common understanding of success - clear outcomes, indicators and measures that agencies and providers can use to measure results, with a focus on understanding how a multi-agency system itself is functioning. Table 14 summarises examples of outcomes and indicators used in performance monitoring and evaluation frameworks from Australian and international child and family systems.³⁵⁹

Table 14 | Key outcomes in performance monitoring and evaluation frameworks³⁶⁰

Domain	Outcome / Indicator
Prevention	<p>All children and young people can:</p> <ul style="list-style-type: none"> • live in supportive families where their physical, emotional and social needs are met • be safe from harm and injury • maximise their physical health, strength and functioning • manage their mental health and wellness • maximise their intellectual ability and functioning and to achieve educational success

³⁵⁵ Ibid.

³⁵⁶ Tune D, 2015, *The Tune Report: Independent review of OOH*

³⁵⁷ Tune D, 2015, *The Tune Report: Independent review of OOH*

³⁵⁸ Ernst and Young, 2016, *Access System Redesign – Preliminary User Segmentation*. Sydney: Ernst and Young.

³⁵⁹ Wise S, 2017, *Developments to strengthen systems for child protection across Australia*. Melbourne: Australian Institute of Family Studies. NSW Ombudsman, 2017, *The JIRT Partnership – 20 years on. NSW Ombudsman inquiry into the operation of the JIRT Program*. Sydney: State of New South Wales. Department for Child Protection and Family Support, 2016, *Outcomes Framework for Children in out-of-home-care in Western Australia: 2015-2016 Baseline Indicator Report*. s.l.; Government of Western Australia. ACIL Allen Consulting, 2015, *Measuring Progress Under the National Framework: An evaluation of progress under the National Framework for Protecting Australia's Children*. Melbourne. FACSAR, 2017, *Applying the NSW Human Services Outcomes Framework in FACS: an overview*. s.l.; NSW Government. Department of Education, n.d., *National Quality Standard Quality Area 2: Children's health and safety*. s.l.; NSW Government. Department of Families, Housing, Community Services and Aboriginal Affairs, 2011, *An outline of National Standards for out-of-home care: A Priority Project under the National Framework for Protecting Australia's Children 2009-2020*. Canberra; Commonwealth of Australia. Haldorsson O, n.d., *Barnahus Quality Standards: Guidance for Multidisciplinary and Interagency Response to Child Victims and Witnesses of Violence*. s.l.; Council of the Baltic Sea States Secretariat and Child Circle. United Nations Children's Fund, 2012, *Measuring and Monitoring Child Protection Systems: Proposed Core Indicators for the East Asia and Pacific Region*. Bangkok; UNICEF. Adamson E, Bromfield L, Edwards B, Gray M, Hilferty F, Katz I, McDonald M, McHugh M, Valentine K, 2010, *Keep Them Safe: Evaluation Framework: Final report*. Sydney; Australian Institute of Family Studies.

³⁶⁰

Early intervention	<ul style="list-style-type: none"> • Surveillance mechanisms for preventing and detecting children at risk of abuse, neglect and violence are comprehensive and effective • Risk factors for child abuse and neglect are addressed • Every reasonable precaution is taken to protect children and young people from harm • Children and young people sexual abuse and exploitation is prevented • Families can access adequate support to promote safety and intervene early
Service response	<ul style="list-style-type: none"> • Children and young people have their physical, developmental, psychosocial and mental health needs assessed and attended to in a timely way • Children and young people who have been abused or neglected receive the support and care they need • Children and young people exposed to multiple risks from different sources receive effective support
Statutory response	<ul style="list-style-type: none"> • Children and young people live in a stable care arrangement safe from further abuse and neglect • Children and young people develop a deep knowledge and understanding of their life-history and identity • Each child and young person has an individualised plan that details their health, education and other needs • Children and young people leave care equipped with the resources to live productive lives • Children and young people have as few placements as possible • Children and young people are supported to safely and appropriately maintain connection with family
Inclusion of the child	<ul style="list-style-type: none"> • Children and young people are included in decision-making processes about their lives • The best interests of the child and young person underpin all actions and decisions concerning the child and young person • Children and young people's rights to express their views and to receive information are respected and fulfilled
Enabling elements	<ul style="list-style-type: none"> • Professional training is provided for personnel working on child protection service delivery • Government has the capacity to attract and retain qualified child protection professionals • Data is collected and shared with relevant stakeholders • The public has an appreciation of the importance of attitudes and values for child protection

Leveraging the evidence on what works for Aboriginal families and communities



An Aboriginal-led outcomes framework is a key enabler of the Aboriginal service system. AbSec proposes that success of interventions for Aboriginal children and families must consider broader community development and empowerment outcomes, including community leadership; workforce development; education; poverty alleviation; and healing of communities.³⁶¹

The Western Australia Outcomes Framework for Children in OOHC include the following outcomes under the domain of belonging:

- children's cultural needs are identified and responded to
- children have a connection with family of origin to support their identity and belonging

³⁶¹ AbSec, 2016, *Achieving a holistic Aboriginal Child and Family Service System for NSW*. Sydney: AbSec.

- Aboriginal children are living within their cultural community.³⁶²

Consultations in Western Australia to develop a shared outcomes framework for family support services more broadly suggested the outcome of developing norms of attending school, seeking employment, paying rent, avoiding criminal behaviour and keeping children safe. The consultation found that the outcomes framework needs to ensure that services don't only take the most responsive clients (meaning that good outcomes are always achieved), as it may be more difficult to achieve outcomes with the most at-risk Aboriginal families.³⁶³

Outcomes related to culture and community evident from other jurisdictions include:

- Children and young people in care are supported to develop their identity, safely and appropriately, through contact with their families, friends, culture, spiritual sources and communities.
- Aboriginal communities participate in decisions concerning the care and placement of their children and young people.³⁶⁴

³⁶² Department for Child Protection and Family Support, 2016, *Outcomes Framework for Children in out-of-home-care in Western Australia: 2015-2016 Baseline Indicator Report*. s.l.; Government of Western Australia.

³⁶³ Department for Child Protection and Family Support, 2016, *Earlier Intervention and Family Support Strategy*. s.l.; Government of Western Australia.

³⁶⁴ Department of Families, Housing, Community Services and Aboriginal Affairs, 2011, *An outline of National Standards for out-of-home care: A Priority Project under the National Framework for Protecting Australia's Children 2009-2020*. Canberra; Commonwealth of Australia.

Appendix A Limitations to the evidence base

This appendix outlines the limitations to the evidence base that inform this paper.

Establishing a strong evidence base is a common challenge in the health and human services sectors.³⁶⁵ In an area as complex as child wellbeing and child protection, there are unique challenges to building the evidence on what works. These include:

- **Determining impact or outcomes of specific model or practice.** Often the impact of a model or practice may only be evident after significant time (for example five to ten years after implementation). Within that time, other interventions may have contributed to any changes in child, parent or family outcomes. The dynamic nature of the experience of vulnerable children and families (i.e. it is not a single incident) means that the context in which programs and services operate is constantly shifting.
- **Confirming absolute attribution to a model or intervention.** Across NSW, multiple interventions with different target cohorts occur in the same region or local community. These interventions have varying intensity (for example a 30-minute screening through to intensive case management or face-to-face counselling). They also occur over different lengths of time (one-off, brief interventions, ongoing support). This means it can be difficult to determine which aspects of any intervention may be working well.
- **Randomised control trials are more fitting for medical interventions;** some trials pose significant ethical issues in the context of vulnerable children and families. While randomised controlled trials can provide robust data, they are more suitable for assessing interventions where all other variables can be isolated. This is not the case for vulnerable children and families, where many variables surround the circumstances in which client's access and use services. There can also be ethical issues with providing best practice support for some clients and not others (i.e. the baseline group).

This review seeks to identify high-quality evidence that should inform the Access System Redesign, within the context of the limitations outlined above.

³⁶⁵ Nous Group, *NSW Family Investment Commission*, prepared for Department of Premier and Cabinet NSW, Sydney, 2016; Department of Premier & Cabinet, *Prevention and Early Intervention Taskforce Report: An examination of the prevention and early intervention system for vulnerable children and their families*, NSW Government Cabinet in Confidence, Sydney, 2014; Council of Australian Governments, *National Plan to reduce violence against women and their children*, 2010; Council of Australian Governments, *Second National Action Plan*, 2013.

Appendix B Evidence on remaining models of practice

This appendix provides the evidence on the models of practice for which there is a medium or low level of evidence on their effectiveness.

It presents the evidence categorised by four core access system components, related to:

- *Identification*: how vulnerable families, children and young people are identified in the community.
- *Engagement and assessment*: how vulnerable families, children and young people engage with the access system and how their level of need and risk (and hence the support or intervention required) is assessed.
- *Coordination of services*: how the required response (whether support or intervention) is coordinated, both between the service and with the vulnerable children and families and between agencies and community organisations.
- *Service responses*: the quality and type of support services provided to vulnerable children and families.

Table 15 lists the 23 models of practice examined in this evidence review, a description of each and the level of evidence identified by this review.

Table 15 | Models of practice examined in this evidence review

Model of practice	Description
Identification	
Community hubs	The community hub model seeks to address issues holistically and in consideration of the broader socio-economic system in which children and families exist. They typically they function as a community-led and designed 'one-stop shop'.
Localised intake service	Intake services are the first point of contact that people use to raise a concern about a child and their family, for example, about suspected child abuse and neglect. ³⁶⁶ Localised intake services refer to intake services that are embedded within local communities and refer people to local services.
Separate advice and reporting line	This refers to the use of two or more separate helplines through which people seek advice on available services and how to support families or make child safety reports.
Combined advice and reporting line	A combined advice and reporting line refers to a single hotline or helpline that provides support and advice for families, as well as a mechanism for reporters to access timely support, respond to and escalate concerns.
Advice and education for mandatory reporters	This refers to the systems, policies and practices in place to ensure people in a mandatory reporter role understand their role and the reporting process. It also refers to the continuing education and advice for mandatory reporters as reforms and changes to the access system occur.
Separate door for urgent cases from qualified reports	This refers to a separate mechanism within the access system that allows urgent cases from qualified reports to be expedited. The intent is to ensure children and families with urgent needs and/or those at-risk of imminent harm are prioritised and receive the right services quickly.

³⁶⁶ Lamont A, Price-Robertson R and Bromfield L, 2010, *Appendix 7.2 Intake, investigation and assessment – background paper*, AIFS. Melbourne; AIFS.

Proactive identification of need/risk	This refers to a mechanism to be able to proactively identify children whose wellbeing may be at-risk and/or who may be at-risk of harm or neglect. It typically relies on intelligence from key people who work closely with children and/or predictive analytics that uses known risk factors.
Out-posted workers	Out-posted workers are professionals who operate separate from their organisations' location to reach difficult-to-reach groups, such as people living in rural or remote locations. Out-posted workers may be in one fixed location or may 'rove' between different services to cover a broader geographic area. ³⁶⁷
Help-seeking	Help-seeking refers to people attempting to find assistance to improve a situation or problem. ³⁶⁸ In the context of the child and families services access system, this could refer to people seeking information about supports or self-referring to services.
Engagement and assessment	
MDTs	An MDT is a collection of professionals from a range of disciplines working collaboratively together to engage and assess children and families. Child abuse investigations and family assessments are inherently complex and require input and action from a variety of agencies, departments and other service providers.
Family involvement in assessment	This element refers to policies, practices and processes that enable families to have a role and a voice in the assessment of risk and needs of their child and family.
Inclusion of the child	This element refers to policies, practices and processes to place children at the centre of the access system and enable them to have a role and a voice in the assessment process.
Triage models and tools	Triage refers to the processes in which children, young people and families who enter the "front door" are screened or assessed to determine the level of priority of risks or needs. Triage is a form of demand management and ensures children and young people at the highest risk are given priority in a system with finite resources.
Assessment frameworks and tools	Assessment tools and frameworks help determine the level of risk and/or need experienced by children, young people and families and the appropriate service response or intervention. The assessment of risk and/or need occurs once a child, young person or family has entered the access system after any initial triage.
Predictive analytic tools	Predictive analytics aims to more accurately predictive the level of risk for a child and the likelihood they will benefit from early intervention services. These tools link existing data sources to produce algorithms that predict the likelihood of future child or family outcomes. They apply analytic techniques to identify risk issues, identify patterns in the data that could not otherwise be observed and stratify them to support decision making. ³⁶⁹
Coordination	
Differential response	A differential response refers to a multi-track system that allows for a tailored response to child protection concerns, based on the identified level of risk. In this model, not all cases of child maltreatment follow the traditional investigative (statutory) response pathway. Alternate response pathways are available to families, generally where a lower level of risk is identified.
Co-location of government agencies	The geographical co-location of government agencies involved in the child protection response and the provision of support services refers to relevant agencies (or major parts of agencies) being physically co-located.
Lead professional	The lead professional model refers an individual who has responsibility for coordination of support for a child or family who is in contact with the access system. ³⁷⁰ The lead professional typically helps the child or family to navigate the system and connect with the right services to address their needs.
Active holding	Active holding refers to the practice of maintaining regular contact with families waiting to access a full suite of services. Active holding aims to maintain a relationship between professionals and family members until a place in the service is available. It seeks to mitigate the risk of families disengaging with the system. ³⁷¹
Service responses	
Demand management	Demand management refers to the effective prioritisation of referrals to manage demand at a system-level (as opposed to service level demand management strategies individual providers may undertake).

³⁶⁷ Victorian Government, 2018, *Support and safety hubs: service model*. s.l.: Victoria Government.

³⁶⁸ Cornally N and McCarty G, 2011, *Help-seeking behaviour: a concept analysis*. International Journal of Nursing Practice, 17(3), pp280-288.

³⁶⁹ University of New England, 2018, *Triage and Assessment Tools: Accessing Help through the Front Door*. Armidale; University of New England.

³⁷⁰ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

³⁷¹ Parenting Research Centre, 2018, *Access system redesign – a rapid evidence assessment of models of triage and segmentation*. Melbourne; Parenting Research Centre.

Universal services	Universal services are available for all children and families in the community. They include essential, basic services and support, such as primary health care, school and early childhood education. Universal services work with children and families from an early age and can prevent issues arising in the first place.
Targeted services	Targeted services are enhanced early intervention services that identify and respond to child and family wellbeing issues early, when they first arise. They typically support children and their families within the community. They maintain child and family wellbeing and aim to prevent the need for children to enter the child protection system.
Intensive and/or statutory services	Intensive services are provided for families where a child is at-risk of neglect or harm. Intensive services are often statutory services, a mandated intervention by the State. They indicate a significant and serious action that only occurs as a last resort.

The evidence for models identified with a low or medium level of evidence is outlined below.

B.1 Identification

Localised intake services

Intake services are the first point of contact that people use to raise a concern about a child and their family, for example, about suspected child abuse and neglect.³⁷² Intake services are typically a telephone-based office response. Localised intake services refer to intake services that are embedded within local communities and typically refer people to local services.

There are few examples of localised intake approaches across NSW. There is limited evidence available that they have been effective and achieved intended outcomes, such as reduced ROSH reports and an increased number of referrals to suitable services. The four examples identified in this evidence review were:

1. **The Western NSW mobile Child Protection Unit** (for regional intake). The Mobile Child Protection Unit in Western NSW is an example of an innovative response to meeting the needs of at-risk children and young people in remote communities. Results achieved to date include:
 - Investigations of ROSH reports were conducted more quickly, including high priority reports and reports relating to children under five years old. There was an 83 per cent increase in the proportion of ROSH reports with a Safety and Risk Assessment completed within the required two-month timeframe (from 30 per cent to 50 per cent).
 - The proportion of high priority ROSH reports that received a response on the same or next day almost doubled, from nine per cent to 17 per cent.
 - Caseworkers' face-to-face contact with families increased, with the total number of home visits conducted in the area rising more than two-fold, from 459 in 2014 to 1,250 in 2015.³⁷³
2. **Family Investment Model**. For more information, see the sub-section on *Multi-Disciplinary Teams*.

Separate advice and reporting line

This refers to the use of two or more separate helplines through which people seek advice on available services and how to support families or make child safety reports.

Currently in NSW, there is one reporting line for child protection and multiple, unlinked and inconsistent advice lines. This includes the Child Protection Helpline for reporting child protection concerns. It also

³⁷² Lamont A, Price-Robertson R and Bromfield L, 2010, *Appendix 7.2 Intake, investigation and assessment – background paper*, AIFS. Melbourne: AIFS.

³⁷³ NSW FACS, 2017, *Mobile Child Protection Unit: early analysis of a new approach to child protection*. FACSAR brief. Sydney: NSW FACS.

includes parenting and advice lines such as Parentline NSW (see the *Help-seeking* in Appendix B), FRS (see the *Community hubs* in section 4.1.1) and the NSW Health, Education and Police CWU lines (to help determine the level of risk and next steps for Mandatory Reporters). Independent and Catholic schools also have localised support structures in place to support reporters.

Evidence shows there are limitations with the current approach in NSW, particularly reaching the appropriate population and the capacity to deal with the client volume. For example, the reporting line, the Child Protection Helpline, does not facilitate access to support and services below statutory threshold; reports must escalate to ROSH before families are referred to a Community Service Centre. When reports do meet ROSH criteria, approximately only 32.2 per cent of these receive a face-to-face assessment when directed to the Community Service Centre (27,793 children and young people in 2016-2017).³⁷⁴

This system leaves a gap of vulnerable children and young people reported to the Child Protection Helpline who do not meet ROSH criteria at the level of the Child Protection Helpline (132,622 children and young people in 2016-2017).³⁷⁵

A cohort that is likely to exist, but cannot be measured, is the number of vulnerable children and young people that are not being reported to the Child Protection Helpline at all. CWUs meet the needs of some mandatory reporters (in terms of providing advice and support to their reporters, referrals and screening out non-ROSH), but not all. They are limited in their reach.³⁷⁶

Many other jurisdictions operate separate advice and reporting lines (or a single reporting line), with minimal evidence identified on the effectiveness of this approach. Table 16 summarises the approach across selected Australian and international jurisdictions and identified evidence.

Table 16 | Examples of separate advice and reporting lines and available evidence on effectiveness³⁷⁷

Model	Region	Description	Evidence
Child Abuse Report Line - single line (reporting only)	South Australia	Mandatory Reporters can report via the centralised Child Abuse Hotline (a reporting line) and the online reporting system; however, serious concerns must be only reported via the report line.	No evidence on effectiveness or outcomes identified.
Dual reporting lines; separate lines for high and medium/low risk reports	Victoria	People can report low/moderate risk cases on a separate line (entry point) through Child FIRST. It provides support for young people and families and referrals (an alternate pathway to the statutory system). It is a community-based service delivered in local areas by local organisations (decentralised delivery). It provides an alternative response to statutory child protection reporting line. The Victoria Department of Health and Human Services manage it.	One study found that the alternate response to the statutory child protection pathway facilitates support to vulnerable families earlier, before statutory intervention is needed. ³⁷⁸
Dual reporting lines; separate lines for high and medium/low risk reports	Queensland	People can contact Family and Child Connect for support and/or advice on available services, particularly for lower risk cases (i.e. when someone is not in immediate danger of being harmed). Child Safety Services managed by the Queensland government remains the hotline for reporting child protection cases or concerns. The hotline is run through regional intake services.	Since it was introduced in 2013, referrals to Child Safety decreased by 16.3 per cent and substantiations have decreased by 20.1 per cent. ³⁷⁹

³⁷⁴ NSW Department of Family and Community Services, 2018, *FACS caseworker dashboard*. Retrieved from <https://public.tableau.com/profile/facs.statistics#1/vizhome/FACScaseworkerdashboard/FACSCaseworkers>.

³⁷⁵ Ibid.

³⁷⁶ FACS, 2016, *Annual report 2015-16, Volume 1*, Sydney: NSW FACS.

³⁷⁷ Based on TFM project team research on jurisdictional approaches to reporting lines.

³⁷⁸ Parenting Research Centre, 2018, *Access system redesign – a rapid evidence assessment of models of triage and segmentation*. Melbourne: Parenting Research Centre.

³⁷⁹ Boston Consulting Group, 2018, *Access Redesign: high level future design and gap analysis*. Unpublished.

Dual reporting lines; separate advice and reporting lines	ACT	There is a central intake via reporting lines, but separate numbers for Mandatory Reporters and the public. There is also an online tool for making reports. These exist separately from advice lines.	No evidence on effectiveness or outcomes identified.
Dual pathways; separate advice and reporting lines	Northern Territory (NT)	The NT has dual reporting pathways. The Child Abuse Hotline is a centralised system to report cases of neglect or harm to a child. Family and Children's Enquiry and Support line is a new and alternative referral point within the non-government sector for advice and concerns rather than allegations. It connects families with supports, services and resources.	No evidence on effectiveness or outcomes identified.
Dual pathways; separate advice and reporting lines	New Zealand	For reporting, New Zealand uses a central intake hotline, staffed through a national contact centre for reports of abuse and neglect. For advice, people have access to Children's Hub. This is a contact point for professionals and practitioners in all areas that have Children's Teams, where they can raise concerns about at-risk children and young people - they do not need to have the consent of the family to make a referral to the hub. The hub undertakes an initial risk and needs assessment and identifies the most appropriate pathway to address those needs. Critical calls are forwarded to the central intake centre.	No evidence on effectiveness or outcomes identified.
Single reporting line; separate advice portal	England – Kirklees Council and Leeds Council	This council uses a single reporting line; however, it is completed by a 'Duty and Advice Team'. This is an alternative front door for practitioners and professionals who work to safeguard children and young people. The Council uses a separate Advice and Referral portal, which is consensus-based.	No evidence on effectiveness or outcomes identified.
Single reporting line for statutory concerns; differential response pathways after intake	US – Washington	Reports are made through local office, either calling the office directly or calling a hotline - Washington State's 24/7 hotline that will connect people to the appropriate local office for making reports. Washington also has the Family Assessment Response (a differential response), which is used after intake and for referral to services.	No evidence on effectiveness or outcomes identified.
Single reporting line for statutory concerns; differential response pathways after intake	US – Connecticut ³⁸⁰	Connecticut has a centralised hotline through which intake and screening occurs. Through this, people who are screened out of the system do not receive assistance. Those who are assessed as needing assistance then have the option for investigation or Family Assessment Response. Family Assessment Response is a differential response and service referral that aims to provide 'ideal' services to meet family needs.	No evidence on effectiveness or outcomes identified.

Combined advice and reporting line

Note: This evidence supports key system element 5: Integrated Advice and Reporting Line and web-based portal.

A combined advice and reporting line refers to a single hotline or helpline that provides support and advice for families, as well as a mechanism for reporters to access timely support, respond to and escalate concerns. It may be available for both members of the public and professionals/mandatory reporters. It typically facilitates a differential response, ensuring that each child/family receives an appropriate and

³⁸⁰ Higgins D, 2018, *High level scan of jurisdictions and design features*. s.l.: Australian Catholic University.

timely response. This model encompasses the principle of adopting a public health approach – that is, moving from crisis response to early identification of need.³⁸¹

NSW does not currently have a state-wide combined advice and reporting line.

There is some evidence that the provision of capable and robust advice and referral services through a single ‘front door’ (helpline) has been shown to improve outcomes for children and reduce pressure on statutory services.³⁸² For example, one study recommended NSW adopt a single, centralised hotline for Mandatory Reporters to use for all cases, regardless of the level of risk, as a method to improve timely access to services. The intake officer on the hotline would assist to determine the required response (for example through a statutory or non-statutory pathway).³⁸³ This single hotline would require significant enabling technology and legislated information sharing practices between agencies (including CWUs, NGO and other agencies).

There are examples of other jurisdictions using a combined reporting and advice line; however, the evidence on the impact this model may have on child and family outcomes is limited. Table 17 summarises the jurisdictions’ approaches.

Table 17 | Examples of combined advice and reporting lines and available evidence

Jurisdiction	Model	Description	Evidence
Tasmania ³⁸⁴	Children’s Advice and Referral Alliance	<p>Tasmania is implementing a centralised combined helpline with co-located services – known as the Children’s Advice and Referral Alliance (CARA).</p> <p>People can make contact the CARA by phone, email, through a dedicated CARA website or by post.</p> <p>It is conversational rather than using formal risk assessment tool. The initial response for all calls is done by a state-wide team. Regionally based teams do triage. Qualified professionals staff the helpline.</p>	No evidence on effectiveness or outcomes available, as this model has not yet been implemented. It is due to be launched in December 2018.

Advice and education for mandatory reporters

This section refers to the systems, policies and practices in place to ensure people in a mandatory reporter role understand their role and the reporting process. It also refers to the continuing education and advice for mandatory reporters as reforms and changes to the access system occur.

This review identified some evidence on the effectiveness of the current approach in NSW. Overall, the evidence indicated that the legislation, policy and guidelines lack clarity, are sometimes unclear about the reporting responsibility and do not have enough of an emphasis on non-statutory child wellbeing responses.³⁸⁵ However, there was also some evidence that mandatory reporters have increased their understanding of how to respond to child wellbeing more broadly (other than the statutory child protection reports and interventions).³⁸⁶

³⁸¹ TFM project definition based on research undertaken as part of the high-level design of the Access System.

³⁸² New Zealand Government, 2015, *Children’s Action Plan: identifying, supporting and protecting vulnerable children progress report*. s.l.; Children’s Action Plan.

³⁸³ Matthews B, 2018, *Research on Reporting of Child Maltreatment*. s.l.: Queensland University of Technology.

³⁸⁴ Department of Health and Human Services, 2016, *Strong Families – Safe Kids: Implementation Plan 2016-2020*. Hobart: State of Tasmania.

³⁸⁵ Matthews B, 2018, *Access system redesign reporter needs*. Unpublished.

³⁸⁶ Matthews B, 2018, *Research on Reporting of Child Maltreatment*. s.l.: Queensland University of Technology.

Currently in NSW, the roles and responsibilities of mandatory reports in Health, Education and Police in relation to child wellbeing are set out in various legislation, policy and guidelines. A review of legislation found a lack of clarity and potentially undue broadening of the scope of provision of the following legislation:

- s27 (mandatory reporting): there is a lack of clarity of the legal definition of ROSH (in the Children and Young Persons (Care and Protection Act) 1988.
- s27A (alternative reporting arrangements): there is lack of clarity, potentially duplication of reporting and unclear allocations of reporting responsibilities and sub-optimal integration of the concept of reporting non-statutory cases to CWUs or other agencies.³⁸⁷

The *Tune Review* found that mandatory reporters see their role as 'to report', meaning they are less likely to refer children at lower risk through alternate channels (such as CWUs, the FRS or another agency or support service). There is some evidence of opportunities to improve the NSW approach to the mandatory reporter role and the education of people in that role.³⁸⁸ For example, a review of the Mandatory Reporter Guide found:

- It is comprehensive and technically excellent, especially for senior staff with advanced knowledge in the area. For some people, the length and complexity of the document may be a deterrent.
- There should be more emphasis and clear instructions on supporting and responding to child wellbeing (other than statutory child protection interventions), given most of contacts do not meet the statutory threshold of risk (under s27a).
- It should provide plain-English definitions of core concepts, particularly safety, welfare, wellbeing, reasonable grounds to suspect, ROSH, DFV, physically abused or ill-treated, serious psychological harm and basic physical and psychological needs.³⁸⁹

There is some evidence that CWUs have improved the effectiveness of mandatory reporting in terms of responding to child wellbeing; however, CWUs have limited reach and do not cover all Mandatory Reporters. For example:

- CWUs have 'significantly advised, supported and educated mandatory reporters'
- 80 per cent of reporters believe the NSW Health CWU increased their confidence to respond to Child Wellbeing or Protection issue.
- Approximately 70 per cent of reporters communicated with other workers/agencies regarding services for children and young people/family because of a CWU contact.³⁹⁰

Separate door for urgent cases from qualified reports

This model of practice refers to a separate mechanism within the access system that allows urgent cases from qualified reports to be expedited. The intent is to ensure children and families with urgent needs and/or those at-risk of imminent harm are prioritised and receive the right services quickly.

This review identified limited evidence on the existence or effectiveness of this practice in NSW or other jurisdictions.

A rapid evidence review undertaken by the Parenting Research Centre examined 12 triage and segmentation models from Australia, Canada, England, New Zealand and the United States, as part of

³⁸⁷ Matthews B, 2018, *Access system redesign reporter needs*. Unpublished.

³⁸⁸ Tune D, 2015, *The Tune Report: Independent review of OOHC*.

³⁸⁹ Tune D, 2015, *The Tune Report: Independent review of OOHC*.

³⁹⁰ Boston Consulting Group, 2018, *Access Redesign: high level future design and gap analysis*. Unpublished.

work undertaken to inform the high-level Access System Redesign. The review found that children who are assessed as being at imminent safety risk are immediately given a 'safety response'. For example, this may be a Police-led response or more responsive local-led response. This study found that an immediate safety response will likely help to avoid delays in investigation, further assessment and service responses.³⁹¹

Proactive identification of need/risk

This model of practice refers to a mechanism to be able to proactively identify children whose wellbeing may be at-risk and/or who may be at-risk of harm or neglect. It typically relies on intelligence from key people who work closely with children and/or predictive analytics that uses known risk factors to identify at-risk children.

No evidence has been identified to date on the existence or effectiveness of this practice in NSW.

One example from an international jurisdiction exists. New Zealand has a 'social workers in schools' program. Evaluations have suggested there are positive outcomes in terms of care and protection notices and police apprehension for at-risk populations.³⁹²

Out-posted workers

Out-posted workers are professionals who operate separately from their organisations' location to reach difficult-to-reach groups, such as people living in rural or remote locations. Out-posted workers may be in one fixed location or may 'rove' between different services to cover a broader geographic area.³⁹³

Two examples of this model in practice were identified – one in NSW and one in Victoria. These are:

- **NSW:** Two examples of out posted workers exist within FRS (a FACS-led initiation) – community services caseworker in FRS offices and the FRS in Schools program. Out-posted community services case workers are based in local FRS offices. The initiative provides children and families who are assessed as 'ROSH less than 10-day response' with a comprehensive assessment and targeted, coordinated service response. The out-posted caseworker and a FRS worker are assigned to case. The initiative has improved responses for eligible children and families and supported collaborative decision making to improve outcomes for children.³⁹⁴ Another example of out-posted workers is Vulnerable Families Coordinator in Health. *This model of practice is also an example of an MDT.*
- **Victoria:** Out-posted workers are part of the Orange Door community hub in Victoria. These out-posted workers have the capacity to deliver the full suite of services (offered at main service hubs). Local area determines their posted locations needs.³⁹⁵ No evidence was identified on the effectiveness of this model. *This model of practice is also an example of an MDT.*

Help-seeking

Help-seeking refers to people attempting to find assistance to improve a situation or problem.³⁹⁶ In the context of the child and families services access system, this could refer to people seeking information about supports or self-referring to services.

There are two examples of services that enable help-seeking behaviours for young people, families and others who may interact with vulnerable children and families. There is some evidence on client

³⁹¹ Parenting Research Centre, 2018, *Access system redesign – a rapid evidence assessment of models of triage and segmentation*. Melbourne: Parenting Research Centre.

³⁹² Boston Consulting Group, 2018, *Access Redesign: high level future design and gap analysis*. Unpublished.

³⁹³ Victorian Government, 2018, *Support and safety hubs: service model*. s.l.: Victoria Government.

³⁹⁴ Boston Consulting Group, 2018, *Access Redesign: high level future design and gap analysis*. Unpublished.

³⁹⁵ Victorian Government, 2018, *Support and safety hubs: service model*. s.l.: Victoria Government.

³⁹⁶ Cornally N and McCarty G, 2011, *Help-seeking behaviour: a concept analysis*. International Journal of Nursing Practice, 17(3), pp280-288.

satisfaction and reported effectiveness of one of the models (Parentline) and evidence on usage of the other model (Family and Child Connect, Queensland).

The two models identified that facilitate help-seeking are shown in Figure 16 overleaf.

Figure 16 | Examples of mechanisms that enable help-seeking behaviour³⁹⁷

MODEL OF PRACTICE	EVIDENCE
<p>PARENTLINE</p> <p>These are state-based helplines available Australia-wide that provide confidential counselling and support for parents and general parent advice and information.</p> <p>Counsellor respond to calls and can provide advice on a range of issues including parenting strategies for challenging behaviours, parent-child relationships, custody and access and the emotional well-being of children and young people.</p>	<ul style="list-style-type: none"> • Parentline QLD and the NT has published client satisfaction and service outcomes from 2011 to 2016. • Overall, 96.3 per cent of survey respondents provided positive ratings regarding their satisfaction with the service provided. • Similarly, 96.2 per cent gave positive ratings regarding Parentline's effectiveness
<p>FAMILY AND CHILD CONNECT</p> <p>This is a QLD government initiative to provide a non-statutory pathway for families to seek assistance and advice (see the 'Community hubs' sub-section for more detail).</p> <p>Family and Child Connect is a local, community-based service that helps families to care for and protect their children and home, by connecting them to the right services at the right time. They may encourage help-seeking behaviours, as they offer an alternate non-statutory pathway for people to access services.</p>	<ul style="list-style-type: none"> • It was rolled out to 20 locations in 2016. • No evaluations of the effectiveness of this model have been conducted to date.

B.2 Engagement and assessment

Predictive analytic tools

Predictive analytics aims to more accurately predict the level of risk for a child and the likelihood they will benefit from early intervention services. These tools link existing data sources to produce algorithms that predict the likelihood of future child or family outcomes. They apply analytic techniques to identify risk issues, identify patterns in the data that could not otherwise be observed and stratify them to support decision making.³⁹⁸

This review identified no evidence on the existence or effectiveness of this practice in NSW. One research report recommended NSW investigate the opportunities of predictive analytics to prevent child maltreatment and critically examine the ethical and community trust aspects. It recommended focusing on the use and merits of predictive analytics at the community level, rather than the individual level. That is, to be able to identify communities in which vulnerable children and families are likely to exist and target early intervention or prevention services to these communities.³⁹⁹

³⁹⁷ E mental health in practice, n.d., *About Parentline*. Retrieved from: <http://www.emhprac.org.au/services/parentline/>. Yourtown, 2016,

Parentline client satisfaction and service outcomes 2011-2016. s.l.: Yourtown. Family and Child Connect, n.d., *How we can help*. Retrieved

³⁹⁸ University of New England, 2018, *Triage and Assessment Tools: Accessing Help through the Front Door*. Armidale; University of New England.

³⁹⁹ Ibid.

B.3 Coordination

Co-location of government agencies (child protection and supportive services)

The geographical co-location of government agencies involved in the child protection response and the provision of support services refers to relevant agencies (or major parts of agencies) being physically co-located.

Evidence from Australian and international jurisdictions highlight the benefits of co-location including:

- ability to share information, including 'soft' intelligence, quickly and easily in a secure environment
- greater collaboration in risk assessments and decisions, with enhanced decisions through input from different perspectives
- a co-ordinated multi-disciplinary response ('one stop shop')
- shorter time frames for decisions and responses
- greater understanding and mutual respect for other agencies work leading to enhanced working relationships between agencies and workers.⁴⁰⁰

Some Australian jurisdictions have examples of co-located and integrated cross-agency teams. For most of the examples, the key agencies involved are police, child protection and health. For many jurisdictions, non-government agencies are integrated into their responses as service providers (for example, sexual assault counselling and casework services). Many of the co-located centres involve separate sections or floors for different agencies, at least in part due to operational reasons. This may affect the degree to which these teams are integrated in practice.⁴⁰¹

Examples of co-location in selected Australian and international jurisdictions include:

- **NSW.** More than half of JIRT's include co-located workers. A survey of the JIRT workforce indicated that many JIRT staff viewed co-location as being central to JIRT's success.⁴⁰²
- **Western Australia:** Family Support Networks in Western Australia provide targeted and integrated secondary support services to vulnerable children and their families. A senior child protection worker from the Department is co-located at each FSN to provide advice and information on child safety and wellbeing concerns.⁴⁰³
- **Tasmania.** Only includes police and child-protection agencies as part of their response, although responders have close contact with the hospitals and services they refer to for forensic medical examinations and counselling services.⁴⁰⁴
- **United States.** Family Justice Centres were established to provide clients with multiple service on the one site ('one stop shop'). The presence of several relevant services on a single site and the promotion

⁴⁰⁰ Thomson Goodall Associates, n.d., *Review of multi-agency models for multi-agency risk assessment and management and integrated service delivery*. Unpublished. Herbert J, Bromfield L, 2018, *National comparison of cross-agency practice in investigating and responding to severe child abuse*. Melbourne; Australian Institute of Family Studies. Home Office, 2014, *Multi Agency Working and Information Sharing Project: Final Report*. s.l.; Home Office.

⁴⁰¹ Herbert J, Bromfield L, 2018, *National comparison of cross-agency practice in investigating and responding to severe child abuse*. Melbourne; Australian Institute of Family Studies.

⁴⁰² NSW Ombudsman, 2017, *The JIRT Partnership – 20 years on. NSW Ombudsman inquiry into the operation of the JIRT Program*. Sydney; State of New South Wales.

⁴⁰³ Thomson Goodall Associates, n.d., *Review of multi-agency models for multi-agency risk assessment and management and integrated service delivery*. Unpublished.

⁴⁰⁴ Herbert J, Bromfield L, 2018, *National comparison of cross-agency practice in investigating and responding to severe child abuse*. Melbourne; Australian Institute of Family Studies.

of those services to agencies and the wider community, was found to have the potential to increase the perceived value and therefore the demand for hub services.⁴⁰⁵

Active holding

Active holding refers to the practice of maintaining regular contact with families waiting to access a full suite of services. Active holding aims to maintain a relationship between professionals and family members until a place in the service is available. It seeks to mitigate the risk of families disengaging with the system.⁴⁰⁶

Active holding responses vary, but may include:

- telephone check-ins
- referral to other services, including universal services
- home visits
- financial aid
- group work
- case conferences.⁴⁰⁷

This review identified two examples of active holding approaches in Australia, with some evidence from the Victorian example that active holding supports family engagement with the access system and may address some family issues.⁴⁰⁸ The two examples were:

1. *FRS in NSW*: When FRS cannot make an immediately referral for a family, they may remain engaged with the family for up to six weeks.⁴⁰⁹ During this time workers, remain in contact with the family to provide support and identify changes in their needs or risks over time.
2. *Child FIRST in Victoria*: One study indicated that the active holding response provided by Child FIRST appears to maintain family engagement while families are waiting for services.⁴¹⁰ The report also identified that some family issues are resolved during the active holding process.⁴¹¹

B.4 Service response

Demand management

Demand management refers to the effective prioritisation of referrals to manage demand at a system-level (as opposed to service level demand management strategies individual providers may undertake). Effective demand management enables referrals to be prioritised based on need and critical, time sensitive or high-risk cases to receive more timely assessments and responses. The overall aim of demand management is to reduce the demand on services.

Benefits of a demand management approach include:

⁴⁰⁵ Thomson Goodall Associates, n.d., *Review of multi-agency models for multi-agency risk assessment and management and integrated service delivery*. Unpublished.

⁴⁰⁶ Parenting Research Centre, 2018, *Access system redesign – a rapid evidence assessment of models of triage and segmentation*. Melbourne; Parenting Research Centre.

⁴⁰⁷ Ibid.

⁴⁰⁸ Parenting Research Centre, 2018, *Access system redesign – a rapid evidence assessment of models of triage and segmentation*. Melbourne; Parenting Research Centre.

⁴⁰⁹ Ibid.

⁴¹⁰ Ibid.

⁴¹¹ Ibid.

- Delayed or reduced demand on the services: this is achieved through prevention and intervention approaches to reduce the number of clients whose risk escalates and need more (and costlier) services.
- Reduced demand costs: this is achieved through using self-service or channel shifting approaches to reduce the costs of managing clients through the system and reducing the demand on costly statutory services.
- Improved knowledge of client groups.
- A better understanding of the cost of providing services.⁴¹²

This review did not identify any examples of system-level demand management in NSW. There are some learnings from Victoria's approach, as it uses demand management in its child and family system, particularly in the Child FIRST model of practice. In Child FIRST, some services use demand management, but not all. Services have developed written demand management strategy that formalises guidance to services on the requirements for demand management, mechanisms, timelines and responsibilities.⁴¹³

Under the Victorian approach, each child or young person undergoes an initial assessment. This determines the agency that is best placed, based on case load and from a service need perspective, to take on the case. The key features of demand management that underpin the Victoria approach are:

- Prioritisation for high risk, complex and vulnerable children, young people and families.
- Initial safety and needs assessments determine the priority of response for each child or young person.
- Children and families are actively engaged during the referral process.
- Case allocation to agencies/services is done in partnership with a service coordination function.
- Data from demand management processes is used to build an understanding of demand and better manage and predict future demand.⁴¹⁴

There are also learnings from demand management approaches in health on what is required for a successful approach. Enablers of a successful demand management approach in health that are relevant for the NSW child and family services context include:

- Requires a continued, locally driven approach through community-based services to focus on prevention and early intervention to reduce demand
- Needs a structured view of demand pain points – for example, managing demand at inflow, flow through the system and outflow. Clients at each stage of this pathway impact demand within a service. Strategies and systems to support best practice are required at each stage.
- Needs effective internal practices within services to ensure efficiency in meeting client needs and monitoring ongoing demand.⁴¹⁵

Intensive and/or statutory services

Intensive services are provided for families where a child is at-risk of neglect or harm. Intensive services are often statutory services, a mandated intervention by the State. They indicate a significant and serious

⁴¹² Rutherford K, 2015, *Demand management project – looked after children business cases*. UNITED KINGDOM Cabinet submission. Retrieved from: <http://moderngov.torfaen.gov.uk/United%20Kingdom/documents/s5965/Demand%20Management.pdf>

⁴¹³ QLD Department of Communities, Child Safety and Disability Services, 2014, *Learnings from Queensland delegation to Victoria to examine Child FIRST service model*. Retrieved from: <https://www.communities.qld.gov.au/resources/reform-renewal/child-and-family/learnings-from-victoria-factsheet.pdf>

⁴¹⁴ Victorian Department of Health and Human Services (DHHS), 2007, *A strategic framework for Family Services*. Melbourne: DHHS.

⁴¹⁵ Vic Health, 2008, *Demand management in community health services*. Online: Vic Health.

action that only occurs as a last resort. State intervention in the lives of children and young people is governed by the Children and Young Persons (Care and Protection) Act 1998 (Care Act) and the Children and Young Persons (Care and Protection) Regulation 2000.

Agencies have undertaken multiple reviews of the NSW child and family system over the past decade (mostly the statutory system), which provided some evidence on what works in the NSW context. Government and non-government agencies have implemented significant changes in response; however, findings from these reviews, particularly the most recent ones, still provide relevant evidence on strengths and limitations of current statutory and/or intensive services in NSW.

The *Tune Review* focused on the OOHC system specifically, however it highlighted some of the challenges facing children who receive statutory services. These include:

- The right supports are not getting to the right people.
- Current practices undermine a holistic response to vulnerable children, young people and their families.
- The statutory and non-statutory systems are not optimised to deliver services effectively.⁴¹⁶

In addition, the *Keep Them Safe Outcomes Evaluation* found there was a gap in the system for children whose families are in high stress or at crisis point, where without immediate intensive intervention the children are likely to be placed in out-of-home care. The needs of these children and families are beyond general family support and early intervention services. They require a specialised and targeted range of intensive family preservation interventions.

To address this gap, the NSW government piloted family preservation services – IFS and IFP. These are for families in which children are at ROSH (and for IFP, at imminent risk of placement in OOHC). Support provided through these services include case work and case coordination, access to brokerage funds, to families where children. IFS and IFP commenced in 2011 and is delivered by contracted NGOs across NSW. An evaluation of these programs showed a significant reduction in child protection reports and OOHC placements for children and young people following the intervention.⁴¹⁷

There are two intensive services run through NSW Health:

- *Child Protection Counselling Services*. This is a specialist, tertiary-level counselling and casework services to children and young people and their families, where Child Protection Services has substantiated that the child or young person has been harmed physically, sexually, psychologically or through neglect. CPCS work involves a medium to long-term intervention (between three months and 18 months). Interventions are child-focussed and family-centred and aim to address and stop the effects of abuse and neglect and exposure to DFV on children and young people.⁴¹⁸ No evidence was identified on the effectiveness of this service.
- *Whole of Family Team*. Whole of Family Teams deliver specialist in-home and community-based interventions for children and families with complex mental health and drug and alcohol issues where one or more children have a substantiated risk of significant harm report. An independent evaluation found that completion of the program led to clinically significant improvements in the parents' mental health; improved parental drug and alcohol outcomes; significant improvements in family functioning (including parenting, family relationships and child wellbeing); and significant improvements in child

⁴¹⁶ Tune D, 2015, *The Tune Report: Independent review of OOHC*.

⁴¹⁷ Cassells R et al., 2014, *Keep Them Safe Outcomes Evaluation Final Report*. Sydney: NSW Department of Premier and Cabinet.

⁴¹⁸ NSW Health, 2018, *Child protection counselling service*. Retrieved from: <https://www.health.nsw.gov.au/parvan/childprotect/Pages/counselling.aspx>

safety with a substantial reduction in the number of children being re-reported to Family and Community Services.⁴¹⁹






⁴¹⁹ Department of Health, n.d., *Whole Family Teams (WFT) Factsheet*. Unpublished.

Appendix C Definitions of risk and vulnerability

This appendix provides definitions of risk and vulnerability. These definitions are often used to identify potential service users and inform which services these users require.

Figure 2 shows definitions of risk and vulnerability used by government agencies.

Figure 17 | Current definitions of risk and vulnerability used by government agencies⁴²⁰

AGENCY	DEFINITION	EXAMPLES
 FACS	A child or young person is at risk of significant harm if the circumstances that are causing concern for the safety, welfare or wellbeing of the child or young person are present to a significant extent.	Neglect of physical, psychological, medical needs and risk of physical or sexual abuse
 JUSTICE	A person is at risk if they have factors putting them on a pathway to offending or re-offending.	Risky behaviour, criminally-minded associates, lack of structured leisure time, past contact with juvenile justice or correctional system
 NSW HEALTH	A person is vulnerable if they have factors adversely affecting their health outcomes in their life situation, using situation specific tools	Antenatal use of drugs or alcohol, signs or symptoms of DFV present
 EDUCATION	A person is at risk if they have factors making it less likely that they will complete their educational milestones.	Frequently changing school, truancy
 AUSTRALIAN INSTITUTE OF FAMILY STUDIES	Families and children are defined as vulnerable to poor outcomes due to multiple and complex needs or lack of resources to support wellbeing and positive family functioning and/or current circumstances.	Lack of financial, physical, personal or social resources; circumstances such as high-conflict separation or divorce

Definitions of vulnerability in the literature vary but tend to be broader than those used by NSW government agencies. For example:

- The OECD broadly refers to vulnerability as ‘the situation where children and families are exposed to risk of harm.’⁴²¹
- The AIFS defines vulnerability in terms of complex needs, lack of resources and current adverse circumstances.
- The UNITED KINGDOM Children’s Commissioner and UNITED KINGDOM Parliament identify specific types of vulnerable children, including children in care, children in the justice system and children living in poverty.^{422, 423}

⁴²⁰ Boston Consulting Group, 2016, *User needs analysis and segmentation*. Unpublished.; Robinson, E, Scott, D, Meredith, V, Nair, L and Higgins, D, 2012, *Good and innovative practice in service delivery to vulnerable and disadvantaged children and families*. CFCA Paper No. 9, AIFS, Retrieved from: <https://aifs.gov.au/cfca/publications/good-and-innovative-practice-service-delivery-vulnerable-and-disadvantaged>.

⁴²¹ Morrone A et al., 2011, *Measuring Vulnerability and Resilience in OECD Countries*, Paris: OECD, Retrieved from: <http://www.iariw.org/papers/2011/morronepaper.pdf>.

⁴²² Cordis Bright, 2017, *Defining child vulnerability: Definitions, frameworks and groups*. Technical Paper 2 in Children’s Commissioner project on vulnerable children. Children’s Commissioner: London.

⁴²³ Select Committee on Welsh Affairs, 2008, ‘Definitions of terms used in the proposed Order.’ *Select Committee on Welsh Affairs Fifth Report*. UNITED KINGDOM Parliament.

The sources for Figure 4 – Common elements of intergenerational trauma are:

1. Morrone A et al, 2011, *Measuring Vulnerability and Resilience in OECD Countries*. Paris: OECD, Retrieved from: <http://www.iariw.org/papers/2011/morronepaper.pdf>.
2. AIFS, 2018, *Good and innovative practice in service delivery to vulnerable and disadvantaged children and families*. Retrieved from: <https://aifs.gov.au/cfca/publications/good-and-innovative-practice-service-delivery-vulnerable-and-disadvantaged/export>.
3. Boston Consulting Group, 2016, *User needs analysis and segmentation*. Unpublished.
4. Robinson, E, Scott, D, Meredith, V, Nair, L and Higgins, D, 2012, *Good and innovative practice in service delivery to vulnerable and disadvantaged children and families*. CFCA Paper No. nine AIFS, Retrieved from: <https://aifs.gov.au/cfca/publications/good-and-innovative-practice-service-delivery-vulnerable-and-disadvantaged>
5. Australian Bureau of Statistics, 2015, *Frameworks for Australian Social Statistics*. Cat No. 4160.0.55.001. June 2015.
6. Cordis Bright, 2017, *Defining child vulnerability: Definitions, frameworks and groups. Technical Paper two in Children's Commissioner project on vulnerable children*. Children's Commissioner: London.
7. Select Committee on Welsh Affairs, 2008, *Definitions of terms used in the proposed Order*. Select Committee on Welsh Affairs Fifth Report. United Kingdom Parliament.

Appendix D MDT models and supporting evidence

This appendix details MDT models across selected Australian jurisdictions and evidence on effectiveness.

Model	Jurisdiction	Description	Evidence
JIRTs	NSW	JIRTs are made up of FACS, NSW Police and NSW Health professionals who undertake a joint investigation of child protection matters. Joint investigation mostly occurs when there is a possibility that the abuse constitutes a criminal offence. There are 23 localised JIRT teams, including 12 co-located teams of FACS, Police and Health staff and 11 co-located teams of FACS and Health staff (with Police separately accommodated but working together).	<ul style="list-style-type: none"> Reduction of negative experiences for children and families during investigation responses. Facilitation of multi-agency information sharing and joint planning and response.⁴²⁴ A recent review of the JIRT recommended the adoption of a child and family advocate role.⁴²⁵
Family Investment Model ⁴²⁶	NSW	This model is a multi-agency, co-located intake, assessment and case management model for families with complex, multi-agency needs. It involves staff, representation and support from FACS, Corrective Services, NSW Police, Juvenile Justice, the Department of Education and NSW Health. It was trailed in Dubbo and Kempsey from August 2016 to August 2018.	An evaluation of FIM is underway.
Multi-agency Investigation and Support Team ⁴²⁷	WA	This involves the co-location of a staff from the Child Abuse Squad Team, NSW Police, FACS and therapeutic support services. The team works with cases primarily related to child sexual abuse by a known offender. They conduct criminal and child protection investigations and facilitate health services for the child. It is distinctive to many other MDTs in Australia as it provides an independent advocate for the child and family as part of the response.	<p>A 2017 Evaluation of MIST found:</p> <ul style="list-style-type: none"> the response seems to be faster in terms of police investigations and assessments the volume of cases appears equivalent if not greater than practice as usual the response seems more child-centred Staff perceptions of MIST are positive and caregivers have high levels of satisfaction.
Multi-Disciplinary Centres ⁴²⁸	Victoria	This is a centre-based response that includes a specialist policing team (Sexual Offences and Child Abuse Investigation Teams), child protection statutory workers, a not-for-profit support agency (Centres Against Sexual Assault) and a specialist unit. It undertakes forensic medical examinations. Centres operate as pilot sites in six areas. At each	No evidence on effectiveness or outcomes identified.

⁴²⁴ Boston Consulting Group, 2018, *Access System Redesign Compendium*. Unpublished.

⁴²⁵ NSW Ombudsman, 2017; Herbert J and Bromfield L, 2017, *Multiagency Investigation & Support Team (MIST) Pilot: Evaluation Report*. Adelaide; Australian Centre for Child Protection. Department of Communities, Child Safety and Disability Services, 2013

⁴²⁶ Ibid.

⁴²⁷ Herbert J and Bromfield L, 2017, *Multiagency Investigation & Support Team (MIST) Pilot: Evaluation Report*. Adelaide; Australian Centre for Child Protection. Department of Communities, Child Safety and Disability Services, 2013

⁴²⁸ Ibid.

		centre, all agencies are co-located, except the specialist forensic medical unit.	
Suspected Child Abuse and Neglect teams ⁴²⁹	Queensland	These teams involve specialist police, child protection, health and education agencies. Thirty teams operate from 21 team coordination points across Queensland. Teams deal specifically with matters that are notifications by Child Safety Services or where Child Safety have responsibility for ongoing intervention and that require coordination across agencies. The response is aimed at sharing information and coordination in complex child protection cases, rather than a process for joint investigations.	No evidence on effectiveness or outcomes identified.
Child Abuse Taskforce	NT	The Child Abuse Taskforce is a co-located response that includes a territory specialist policing unit, federal police and child protection agencies. There are two centres (Darwin and Alice Springs). The taskforce deals specifically with serious and complex matters requiring joint investigation.	No evidence on effectiveness or outcomes identified.

⁴²⁹ Ibid.

Appendix E Early childhood interventions to support positive health and developmental outcomes

This appendix provides detail on evidence-based interventions that have a positive and protective impact on developmental, health and wellbeing outcomes – focused on the first 2000 days of life (see Figure 18).

Figure 18 | Interventions to support health development in the first 2000 days

	<p>Promoting cellular health</p> <p>Physical and psychological harm for mothers, fetuses and infants can negatively impact on the long-term cellular health children.</p> <p>Strategies to promote cellular health include prenatal care, protecting children from harm, reducing inequality, cleaning up environmental toxins and improving food policies to ensure everyone has access to fresh, healthy and affordable food – and at the individual level – stress reduction, exercise, longer sleep, healthy eating, close relationships and exposure to nature.⁴³⁰</p>
	<p>Promoting microbiome health</p> <p>A healthy and diverse microbiome in infants has a major impact on their immune systems and health outcomes. Achieving a full and healthy microbiota in the first 1000 days in particular has been found to be critical for good health the prevention of disease later in life.</p> <p>Strategies to promote microbiome health include curbing unnecessary use of antibiotics (including in meat), reducing exposure to antibacterial products, reducing caesareans, changes to diet and treatments to restore microbes.⁴³¹</p>
	<p>Promoting healthy nutrition</p> <p>Nutrition of mothers and in infancy shapes a child's lifelong health and wellbeing.</p> <p>Researchers identify nutrition as one of the most effective and easiest strategic to improve early childhood outcomes. There are a range of evidence-based guidelines and interventions to promote health nutrition for mothers and infants.⁴³²</p>
	<p>Promoting healthy environments</p> <p>Chemical exposures during pregnancy and early development are major causes of neurodevelopment disorders with lifelong impacts.</p> <p>Treatment options are limited and therefore the focus should be on reducing and preventing exposure to toxins in food, water and the physical environment for mothers and infants, as well as mothers' exposure to tobacco, alcohol and illicit substances in the preconception, pregnancy and breast-feeding periods.⁴³³</p>
	<p>Quality care, stimulation and education</p> <p>Quality care, positive stimulation and early childhood education by care givers and through formal programs has a significant impact on a child's cognitive, behavioural and emotional development as well as their longer-term health, education and employment outcomes. Conversely, trauma, abuse and neglect in the early years can have a severe negative impact on children across their lifetimes.</p> <p>Strategies to promote positive experiences, stimulation and education include positive parenting programs, therapeutic and other supports to assist families manage and recover from trauma, early childhood education starting from infancy and other family and community supports to reduce stress and support the overall wellbeing of families.⁴³⁴</p>

⁴³⁰ Blackburn, E.H. and Epel, E.2017. The Telomere Effect: A Revolutionary Approach to Living Younger, Healthier, Longer. London, UNITED KINGDOM.

⁴³¹ Blaser, M.J. 2014. Missing Microbes: How the Overuse of Antibiotics Is Fueling Our Modern Plagues. New York: Henry Holt and Company.

⁴³² Prescott, S. 2015. Origins: An early life solution to the modern health crisis. Perth, WA: The University of Western Australia Publishing.

⁴³³ Heyer, D.B. and Meredith, R.M. (2017). Environmental toxicology: Sensitive periods of development and neurodevelopmental disorders. *Neurotoxicology*, 58, 23–41.

⁴³⁴ Britto P R, 2017, *Early Moments Matter for every child*. UNICEF, New York. Retrieved from https://www.unicef.org/publications/files/UNICEF_Early_Moments_Matter_for_Every_Child.pdf.