Child Protection Counselling Services Policy and Procedures

Summary The purpose of this document is to support CPCS in working towards best practice with children, young people families and carers in collaboration with the broader service system; clarify the roles and expectations of CPCS and support consistency of practice across NSW.

Document type Policy Directive

Document number PD2019_014

Publication date 29 March 2019

Author branch Government Relations

Branch contact (02) 9424 5751

Review date 29 March 2025

Policy manual Not applicable

File number H18/104639

Status Review

Functional group Clinical/Patient Services - Baby and Child

Applies to Ministry of Health, Local Health Districts, Specialty Network Governed Statutory Health Corporations

Distributed to Ministry of Health, Public Health System

Audience Child Protection Counselling Services Management, Clinical Workforce, Executives for LHDs/SHN

Secretary, NSW Health

POLICY STATEMENT

CHILD PROTECTION COUNSELLING SERVICES (CPCS) POLICY AND PROCEDURES

PURPOSE

This Policy specifies the procedures and minimum standards for delivering Child Protection Counselling Services (CPCS), and sets out the NSW Health framework for effective clinical practice in responding to children and young people who have been exposed to violence, abuse and neglect.

MANDATORY REQUIREMENTS

This Policy requires that Child Protection Counselling Services:

- Prioritise the safety and wellbeing of children and young people who have been exposed to violence, abuse and neglect.
- Provide interventions to increase safety and reduce trauma tailored to each child/young person and their family/carers, underpinned by the following common objectives:
    - Work with interagency partners to reduce current risks for the child or young person so they are in a safe and nurturing environment free from violence.
    - Increase the capacity of parents and/or carers to:
        - understand impacts of violence, abuse and neglect on the child or young person; and
        - meet the specific needs of the child or young person.
    - Ameliorate the impacts of violence, abuse and neglect for the child or young person and their family.
    - Increase stability and opportunities for the child or young person's optimal development and wellbeing.
    - Work collaboratively with interagency partners to facilitate access to appropriate services in a timely and consultative manner.
- Deliver services in ways which increases safety and minimises harm.
- Integrate with NSW Health Violence, Abuse and Neglect services.
- Comply with NSW Health Violence, Abuse and Neglect Service Standards.

IMPLEMENTATION

Chief Executives are responsible and accountable for:

- Establishing mechanisms to ensure the directives and requirements of the Child Protection Counselling Services Policy and Procedures are applied, achieved and sustained;

- Ensuring that NSW Health staff understand and are aware of their obligations in relation to the Child Protection Counselling Services Policy and Procedures and related policies and procedures;
- Ensuring resources are available to deliver and meet the directives and requirements of the Child Protection Counselling Services Policy and Procedures;
- Ensuring that NSW Health staff are trained to operationalise and implement the Child Protection Counselling Services Policy and Procedures;
- Communicating with the Ministry of Health through the Prevention and Response to Violence, Abuse and Neglect (PARVAN) Unit on reporting, communications and performance in relation to the Child Protection Counselling Services Policy and Procedures; and
- Ensuring NSW Health staff are advised that compliance with the Child Protection Counselling Services Policy and Procedures is part of their patient / client care responsibilities.

Child Protection Counselling Services managers are responsible for:

- Ensuring the requirements of the Child Protection Counselling Services Policy and Procedures are disseminated and implemented in their service; and
- Monitoring implementation and compliance with the Child Protection Counselling Services Policy and Procedures.

NSW Health workers are responsible for:

- Implementing and complying with the directives and requirements of the Child Protection Counselling Services Policy and Procedures.

REVISION HISTORY

Version	Approved by	Amendment notes
March-2019 (PD2019_014)	Dr Nigel Lyons, Deputy Secretary, Strategy and Resources	This is the first statewide policy and procedures specifically for the Child Protection Counselling Services.

ATTACHMENTS

1. Child Protection Counselling Services Policy and Procedures

Child Protection Counselling Services Policy and Procedures

NSW GOVERNMENT Health

PROCEDURES

Issue date: March-2019

PD2019_014

Contents

Statement of commitment to Aboriginal families and communities

Aboriginal people are the first peoples of Australia, and are part of the longest surviving culture in the world. With more Aboriginal people living in NSW than in any other Australian state or territory, improving the health and wellbeing of Aboriginal communities is a key focus for the NSW Government. It is the resilience of Aboriginal people that provides the very foundation upon which further efforts to improve Aboriginal health and wellbeing can be made (NSW Ministry of Health, 2012).

The consequences of colonisation as well as social determinants of health, such as education, employment, and housing, have had a devastating impact on the social, emotional, economic, and physical living conditions of Aboriginal people for over 200 years. These factors continue to directly contribute to the health disparities experienced by many Aboriginal communities, and the significant over-representation of Aboriginal children and young people in the statutory child protection system. An appreciation of these factors is critically important to closing the health gap between Aboriginal and non-Aboriginal people.

NSW Health recognises that Aboriginal health encompasses not only the physical wellbeing of an individual, but also the social, emotional and cultural wellbeing of the whole community within which each individual is able to achieve their full potential as a human being (National Aboriginal Health Strategy Working Party, 1989). As such, there exists an appreciation that the health of each individual is inextricably linked to the health and wellbeing of the wider community.

Aboriginal children and young people, like non-Aboriginal children and young people, are vulnerable to the impact of trauma through direct exposure to an accident, family violence and abuse (Atkinson, 2013). In addition to this, it is important to acknowledge the individual and collective experiences of trauma from historical events associated with the colonisation of Indigenous land and genocide can be profound. The passing of trauma legacies through generations to children is commonly known as inter-generational trauma.

Although the effects of childhood trauma can be severe and long lasting, recovery can be mediated by interventions that nurture the spirit, resilience and cultural identity of Aboriginal families and communities. Genuine appreciation and understanding of the impact of power dynamics, the importance of Aboriginal worldviews, and the limitations of Western approaches in the assessment and treatment of trauma is central to demonstrating respect for the lived experiences of Aboriginal people.

NSW Health is committed to improving the health and wellbeing of Aboriginal families and communities in NSW by supporting the ongoing efforts of Aboriginal people and their communities in reducing the impact of the social determinants of health and the effects of individual and collective trauma legacies. NSW Health recognises the significance of family and community to identity, and is committed to Aboriginal families being connected and determining their own futures.

Part One: Understanding the issues

1 Introduction

1.1 Background

The Child Protection Counselling Services (CPCS) Policy and Procedures document was developed by NSW Health in partnership with Berry Street and Dr Jenny Dwyer. The purpose of this document is to:

- support CPCS in working towards best practice with children, young people families, and carers in collaboration with the broader service system;
- clarify the roles and expectations of CPCS; and
- support consistency of practice across NSW.

Achieving and maintaining quality in service delivery requires strong leadership, a capable and committed workforce, collaboration with other services, and clarity and consistency of purpose, standards and guidelines. Achieving quality for a service working with people who have experienced trauma also requires a trauma-informed approach. The aim of this Policy and Procedures document is to contribute to continuous quality improvement processes of the CPCS. It describes practice expectations throughout service delivery and the overarching framework within which it operates.

The CPCS Policy and Procedures is in keeping with relevant state and national policies and legislation. It has been informed by: the National Standards for Mental Health (2010); previous draft CPCS program guidelines; standards for related programs; consultations and feedback from CPCS, Family and Community Services (FACS) and other stakeholders; a review of the literature; and the work and guidelines of a similar program in Victoria (Berry Street Take Two). It is designed to support the work of CPCS to achieve its aims within a continuous quality improvement framework.

To be consistent with the *Children and Young Persons (Care and Protection) Act 1998*, throughout this document the word 'children' is used to refer to anyone under the age of 16 and 'young people' for people aged 16-17 years old. Occasionally, however, the term child is used to describe someone under 18 years old, particularly when quoting original sources.

1.2 Violence Abuse and Neglect as a public health issue

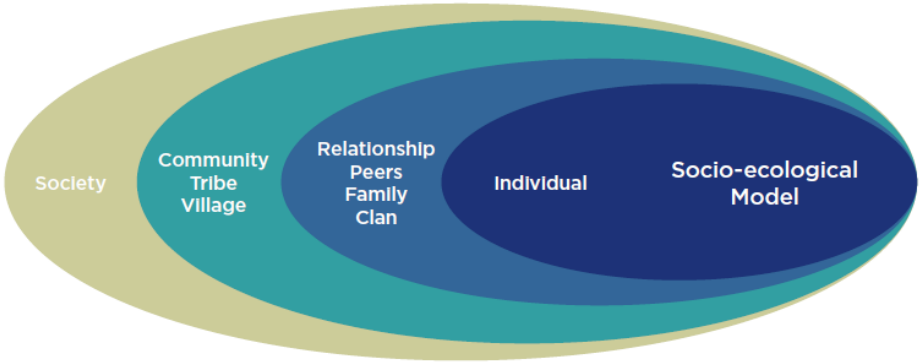
In 1996 the World Health Assembly declared violence a major public health issue and in 2002 released the first *World Report on Violence and Health*, stating:

> The public health sector is directly concerned with violence not only because of its huge effect on health and health services, but also because of the significant contributions that can and should be made by public health workers in reducing its consequences. Public health can benefit efforts in this area with its focus on prevention, scientific approach, potential to coordinate multidisciplinary and multi-sectoral efforts, and role in assuring the availability of services for victims. (Krug, Mercy, Dahlberg, & Zwi, 2002, p. 1083).

The World Health Organization recognises that violence results in both immediate and long term negative health consequences to the individual, their family and the community. They argue that the effects of violence are serious, continue long after the abuse has ended and, for many victims, are life-long. People who have experienced or been exposed to violence have a greater risk of developing a range of poorer health outcomes, report poorer physical health overall, are more likely to engage in practices that are harmful to their health, and experience difficulties accessing the appropriate health service (World Health Organization [WHO], 2002). A summary of the evidence on the extensive health consequences of violence, abuse and neglect is at Appendix 1.

The World Health Organization promotes a public health approach to violence, abuse and neglect built on the socio-ecological model where violence is understood as "the result of the complex interplay of individual, relationship, social, cultural and environmental factors" (WHO, 2002, p. 12), as illustrated in Figure 1 below (adapted from WHO, 2002, 2004, by the NSW Health Education Centre Against Violence)[1].

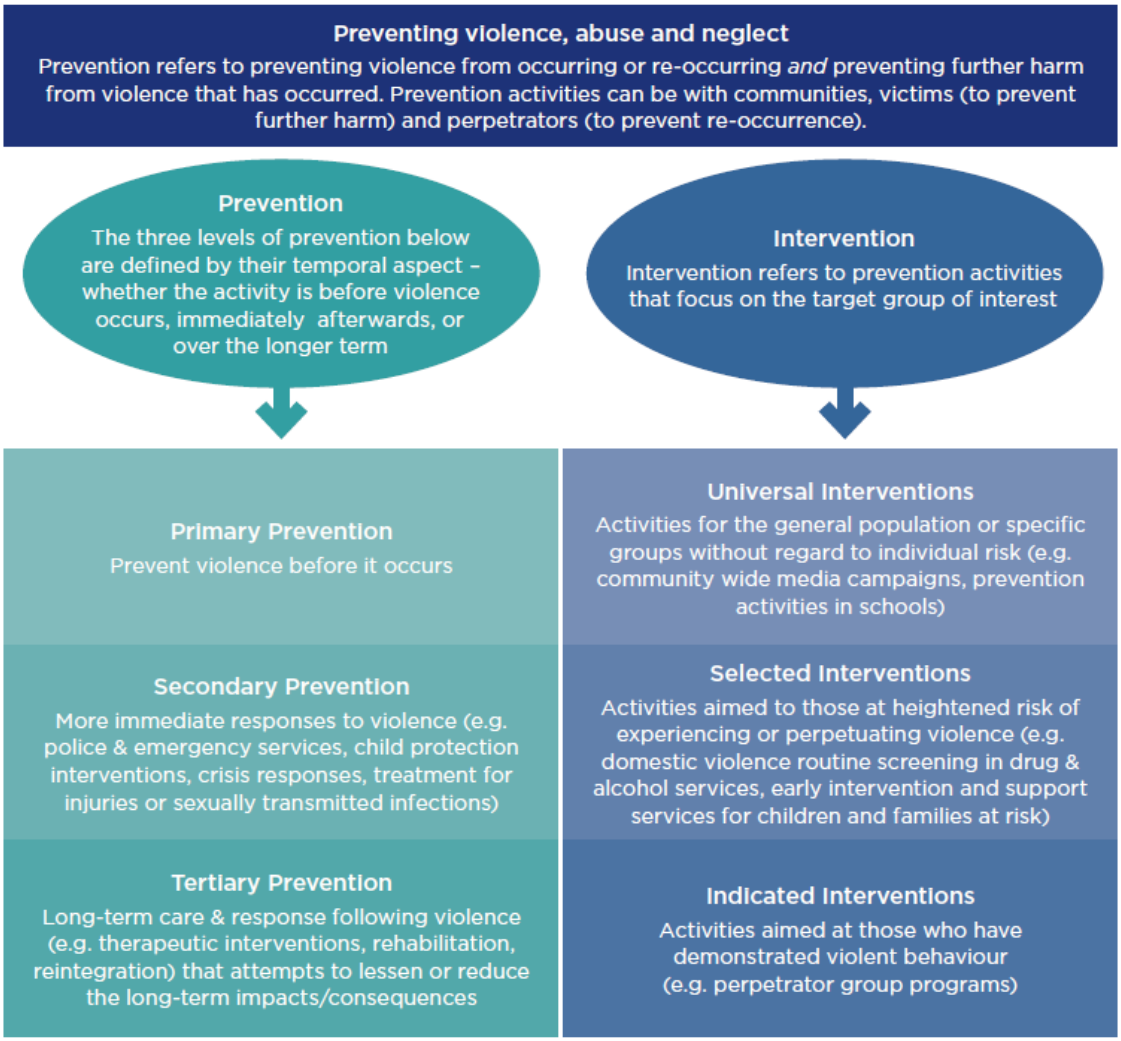
Figure 1: Socio-ecological model for understanding violence



This public health approach argues violence is a problem that is preventable, and its impact can be reduced similarly to other public health concerns (e.g. infectious diseases). The public health approach to violence includes: being evidence-based; emphasising collective action, collaboration and integration across many sectors and disciplines; and focusing on prevention, both of violence occurring or re-occurring and preventing further harm from violence that has occurred (WHO, 2002, 2004). The public health model conceptualises prevention as illustrated in Figure 2 below (developed from WHO, 2002, p. 15).

[1] A socio-ecological model adapted specifically for violence, abuse and neglect involving children is also provided in Appendix 3.

Figure 2: Public health approach to prevention



Alongside common health consequences of all forms of violence, abuse and neglect, their underlying causes are similar: gender and other social inequalities, developmental inequality in the case of children and young people, and dynamics of power and control. Further, many people's experiences of different types of abuse are intertwined and occur across their life span (Herman, 1997). The research and literature also provides evidence of the significant co-occurrence of forms of violence, abuse and neglect as well as their relationship to children and young people with problematic or harmful sexual behaviour (see Appendix 1). It is evident that one type of abuse rarely occurs in isolation from others, and a single abusive experience is often the exception rather than the norm (Laing, 2018). The health and other impacts of different types, and multiple episodes of, abuse is also cumulative (Golding, 1999; Laing, 2018; Taft, 2003; WHO, 2002). This is consistent with messages about the interconnection of the different forms of violence, abuse and neglect that families entering the health system give us when they seek support.

1.3 NSW Health responses to violence, abuse and neglect: promoting an integrated approach

"Violence, abuse and neglect" (VAN) is used here as an umbrella term for three types of interpersonal violence that are widespread in the Australian community: all forms of child abuse and neglect, domestic and family violence, and sexual assault. While the dynamics in each sub-group can differ, there is a high degree of connection and overlap in the experience of, and responses to, these issues. There is also a substantial connection and overlap between violence, abuse and neglect and children and young people with problematic or harmful sexual behaviour. In NSW, there is currently a fragmented response with each issue having its own history, philosophies, policies, services, practices and cultures. As a result, policy and service responses to violence, abuse and neglect have historically operated as silos for which there have been meetings at some intersections but not a consistent integrated response.

Women, men, children and young people may enter the NSW Health system with health issues that are either a direct or indirect consequence of violence, abuse and neglect. A history of violence, abuse and neglect is, however, usually not disclosed when presenting to a generalist health service. While presentations directly to specialist services (e.g. Child Protection Counselling Services) make the obvious link between experiences of violence, abuse and neglect and an individual's health, there are significantly more health service presentations for these issues that are less straight forward. In many circumstances, the person would not have made the connection between their experiences of violence, abuse and neglect and the health complication they are seeking treatment for.

The complexity of the prevalence, health impacts, causes, and responses to violence, abuse and neglect, and by association children and young people with problematic or harmful sexual behaviour, necessitates a whole-of- health-system response. Although responding to these issues is the responsibility of the whole health system, some services have a particularly important role to play in the prevention, identification and response to violence, abuse and neglect. This includes violence, abuse and neglect specific services (e.g. Sexual Assault Services) which work across the spectrum of prevention and intervention, as well as targeted (secondary) and universal (primary) responses from a range of identified health services. A full list of these identified NSW Health services and their respective roles and responsibilities regarding violence, abuse and neglect is at Appendix 2.

NSW Health is undertaking substantial work to integrate and reorient services, policies and clinical practice to ensure consistent and comprehensive responses to all forms of violence, abuse and neglect from both violence, abuse and neglect-specific and mainstream health services, as well as child and adult services. This is part of a broader cultural shift towards person-centred, family-focused, trauma-informed, strengths-based and collaborative care and practice in NSW Health. This cultural shift recognises the important role health systems play in addressing the adverse impact of violence, abuse and neglect on people's safety, health and wellbeing. Of particular note here are:

1. efforts to communicate the responsibilities all Health workers have regarding these issues and build capacity in the broader Health system to respond to violence, abuse and neglect with support from the specialist services;
2. to realign our specialist violence, abuse and neglect services to ensure they have expertise and provide appropriate integrated responses to all forms of violence, abuse and neglect, and not solely those issues for which they have primary responsibility; and
3. the importance of health service prevention and intervention activities at all levels of the socio-ecological model (individual, relationship, community and society).

1.3 Use and structure of this Policy and Procedures document

The CPCS Policy and Procedures is designed for NSW Health Child Protection Counselling Services (CPCS). It reflects the current point in time, where NSW Health is starting to develop whole-of-health-system integrated ways of working in responding to violence, abuse and neglect. This means that NSW Health continues to have CPCS while at the same time developing varied innovative integrated work in responding to violence, abuse and neglect across the Local Health Districts and Sydney Children's Hospitals Network. In this context, the CPCS Policy and Procedures focuses on the forms of violence, abuse and neglect CPCS have primary responsibility to respond to: physical and emotional abuse and neglect of children and exposure to domestic and family violence. It also provides guidance on CPCS service delivery, administrative, and service management issues. The information provided within the Policy and Procedures is also likely to be of value to other NSW Health workers providing services to children and young people who have experienced child abuse and neglect and their families/carers, particularly workers from other specific violence, abuse and neglect services (e.g. Sexual Assault Services).

Reflecting this context, this Policy and Procedures document is structured into three main parts:

1. **Part One: Understanding the issues** (Sections 1-3) provides information and guidance to the whole NSW Health system on violence, abuse and neglect involving children and young people. This includes an introduction to the issues, context and framework for effective practice. Information in this part and many of the appendices is also designed to be a resource (e.g. by providing reliable statistics and other evidence) that NSW Health workers can draw on for a range of purposes, such as presentations and funding proposals.
2. **Part Two: Responding to violence, abuse and neglect involving children and young people** (Sections 4-8) provides information and clinical guidance on referral, intake and the key roles, responsibilities and services provided by CPCS. These sections are structured to reflect a standard client service pathway through a NSW Health CPCS, but also provide guidance on referral pathways and good practice for other services responding to these children/young people and their families/carers.

3. **Part Three: Child Protection Counselling Services management** (Sections 9-10) provides information on records, privacy and information-sharing, governance and service management for CPCS.

As a violence, abuse and neglect service, CPCS are expected to work with other forms of violence, abuse and neglect, and related issues — including child sexual assault, children under 10 with problematic or harmful sexual behaviours, domestic and family violence (working with both victims and perpetrators[2]), adult sexual assault, and adult survivors of child sexual assault — where these are secondary presenting issues that impact on the safety and support of the child/young person. In these circumstances, the clinical practice of CPCS staff should be guided by relevant NSW Health policy, including, but not limited to: *Sexual Assault and Children under 10 with Problematic or Harmful Sexual Behaviours Policy and Procedures Manual* (in development) and *Domestic Violence — Identifying and Responding*.

1.4 Description of the Child Protection Counselling Services

Child Protection Counselling Services (CPCS) have been in operation since 1997, when they were originally known as Physical Abuse and Neglect of Children (PANOC) Services. NSW Health currently funds and operates a network of CPCS across NSW; with a CPCS located within each NSW Local Health District. CPCS work in collaboration with other NSW Health violence, abuse and neglect services such as Sexual Assault Services, Joint Child Protection Response Program (the Program), Whole Family Teams, and New Street Services.

CPCS are child/young person and family/carers-centred trauma-specific services responding to violence, abuse and neglect involving children and young people. Their overarching purpose is to work towards the recovery and ongoing safety and wellbeing of children and young people involved with the child protection system. CPCS work with children of all ages and young people up to the age of 18 years and their families/carers who have experienced, or are believed to have experienced:

- physical or emotional abuse;
- neglect; and/or
- exposure to domestic and family violence.

The services aim to assist children/young people to recover from violence, abuse and/or neglect, and support them to achieve safety, security and permanency, to:

- stay with their family (family preservation); or
- return to live with their family (family restoration); or
- remain in their current placement or move to a more sustainable placement (placement stability).

[2] In line with Domestic Violence — Identifying and Responding Policy Directive

1.4.1 Client group

CPCS provide trauma-specific services for:

1. Children and young people who have experienced physical or emotional abuse, neglect, and/or exposure to domestic and family violence.
2. Children and young people for whom the referrer has identified through a clinical assessment and consultation with interagency partners that a child/young person may have been physically or emotionally abused, neglected or exposed to domestic and family violence, and is likely to benefit from a trauma-specific intervention.
3. Families and carers of the children and young people identified above, regardless of whether the child/young person is in their care.

1.4.2 Scope of the CPCS

CPCS provide services to three main groups:

- the client group listed above;
- professionals; and
- communities.

CPCS are responsible for delivering high quality, culturally responsive and safe clinical services to their client groups. The key client services provided by CPCS aim to address safety and vulnerability in children and young people, and respond to immediate and longer-term health impacts of child abuse and neglect. Services include:

- referral and intake.
- assessment of safety, welfare and wellbeing and ongoing support needs, and intervention planning.
- interventions (i.e. establishing safety, information and support, therapeutic interventions such as counselling, and case work, client advocacy and systems interventions).
- clinical reviews.

The key services provided to professionals and communities are: professional consultation and training, systems advocacy, community engagement, education, and prevention work.

2 Context

2.1 Framing the issues: Violence, abuse, and neglect involving children, young people and their families

Violence, abuse and neglect involving children and young people is recognised by the World Health Organization (WHO, 2014) as a serious public health and human rights issue with long-term personal, social, health and economic costs to children, young people and their families/carers as well as to the broader community. The consequences of violence, abuse and neglect are wide-ranging, varied and include impacts on all

aspects of the child/young person's development which, if are left unaddressed, have the potential to stay with the child/young person as they move into adulthood. Dealing with the impacts of trauma resulting from violence, abuse and neglect is often one of the key reasons a child/young person will be referred to CPCS. The section below summarises key concepts relating to violence, abuse and neglect. More detailed information, including prevalence and impacts, can be found in Appendix 1.

2.1.1 Child abuse and neglect

Child abuse and neglect describes different types of maltreatment of a child, both of which are outlined below. Various forms of child abuse and neglect can be a criminal offence under the *Crimes Act (1900)*. Child abuse and neglect usually occurs within the context of adult-child/young person relationships where the child or young person trusts the adult and relies on them for basic needs.

Child abuse is a term commonly used to refer to different types of maltreatment inflicted on a child or young person. It includes physical harm, assault (including sexual assault), ill treatment and exposing the child or young person to behaviour that might cause psychological harm. Child abuse is an offence under Section 227 of the *Children and Young Persons (Care and Protection) Act 1998*.

Neglect, as distinct from abuse, refers to the failure by a parent or caregiver to provide a child (where they are in a position to do so) with the conditions that are culturally accepted in a society as being essential for their physical and emotional development and wellbeing (Broadbent & Bentley, 1997; Bromfield, 2005; Scott, 2014). Neglectful behaviours can be divided into different sub-categories, which include:

- supervisory neglect: characterised by absence or inattention and can lead to physical harm or injury, sexual abuse or, in an older child, permitting criminal behaviour;
- physical neglect: characterised by the caregiver's failure to provide basic physical necessities, such as safe, clean and adequate clothing, housing, food and health care;
- medical neglect: characterised by a caregiver's failure to provide appropriate medical care. This could occur through a failure to acknowledge the seriousness of an illness or condition, or the deliberate withholding of appropriate care,
- emotional neglect: characterised by a lack of caregiver warmth, nurturance, encouragement and support (emotional neglect is sometimes considered a form of emotional maltreatment);
- educational neglect: characterised by a caregiver's failure to provide an education and the tools required to participate in the education system; and
- abandonment: when a caregiver leaves a child alone for more than a reasonable period and does not provide for the presence of alternative age-appropriate care (where the substitute carer is capable of caring for the child) (Scott, 2014).

2.1.2 Domestic and Family Violence (DFV)

> Domestic and family violence includes any behaviour in a domestic relationship[3], which is violent, threatening, coercive or controlling and causing a person to fear for their own or someone else's safety. It is usually manifested as part of a pattern of controlling or coercive behaviour. (NSW Department of Justice, 2014).

A summary of the types of behaviours that may constitute domestic and family violence is provided in Appendix 1.

NSW recognises that children/young people's exposure to domestic and family violence constitutes maltreatment, even if they are not a direct victim of the violence. Exposure to domestic and family violence poses a risk to a child/young person's physical, emotional and psychological safety. The harmful effects on the developmental and emotional wellbeing of exposure to domestic and family violence are clear and there is increasing attention on children/young people as victim-survivors of domestic and family violence in their own right, with their own unique risks and service needs (Fitz-Gibbon, Maher, McCulloch, & Segrave, 2018; Laing, Heward-Belle, & Toivonen, 2018).

2.1.3 The nature of violence, abuse and neglect involving children

With the exception of child sexual abuse, children are most likely to be abused or neglected by parents and/or caregivers (Australian Bureau of Statistics, 2005; May-Chahal & Cawson, 2005; Sedlak et al., 2010). Research suggests that child sexual abuse is perpetrated by a wider group of people, including parents, other relatives, siblings, friends, or others known to the child (e.g., sports coach, teacher, priest). Although types of child abuse and neglect rarely occur in isolation, and many children and young people may experience chronic and multiple types of abuse and neglect, research data regarding perpetrators of child abuse and neglect tend to isolate incidents into one form of abuse so it is difficult to make conclusions about whether mothers or fathers are those who are more likely to abuse children (D Scott & Meredith, 2014). Nevertheless, it has been noted that "[g]iven that fathers provide, on the whole substantially less direct child care than mothers … [the high] proportions of father and possible father surrogates as perpetrators of severe child abuse appear as rather startling" (Guterman & Lee, 2005, p. 136). Further, the gendered nature of domestic and family violence indicates that perpetrators of domestic and family violence are predominantly male and may be the child or young person's father, stepfather, or carer.

2.1.4 Vulnerability to Abuse

There is no single known cause of child abuse. It occurs across all socio-economic, religious, cultural, racial and ethnic groups. The *National Framework for Protecting Australia's Children 2009-2020* (Council of Australian Governments [COAG], 2009, p. 21) states that the problems most commonly associated with the occurrence of child abuse and neglect and identified in families involved with child protection services are:

- domestic and family violence;

[3] Domestic relationships include intimate partner relationships and family relationships.

- parental alcohol and drug abuse; and
- parental mental health problems.

NSW Health recognises that children and young people living in families where the following risk factors exist have increased vulnerability to abuse and neglect:

- poverty and social isolation;
- unstable family accommodation and homelessness;
- poor child and maternal health;
- children/young people with a disability;
- children/young people with mental health issues, and/or behavioural problems;
- young people disconnected from their families, schools and communities; and
- past experiences of trauma.

2.1.5 Cumulative harm and the impact of violence, abuse and neglect on children and young people

Each child/young person will respond differently to trauma experienced from violence, abuse and neglect. Critical factors that influence the way child abuse and neglect affects children and young people include: the frequency and duration of maltreatment and abuse and the co-occurrence of multiple forms of maltreatment (Hunter, 2014). Cumulative harm (or chronic maltreatment) is used to describe ongoing recurrent incidents of maltreatment or harm experienced by children/young people over a prolonged period of time (Bromfield & Higgins, 2005; Price-Robertson, Rush, Wall, & Higgins, 2013). Cumulative harm may involve repeated exposure to a single adverse event by a single perpetrator, or multiple adverse events with multiple perpetrators over a period of time.

When the child/young person is experiencing neglect, it is often over time that the risk of harm becomes significant harm due to the cumulative nature of neglect. This differs from other forms of maltreatment, like physical or sexual abuse, which are often incident-based and have more explicit signs of impact. In terms of neglect, the chronicity, severity, frequency and duration of neglect play a role in the impacts experienced. This is explored more in Appendix 1.

2.1.6 Impact on development

Experiencing trauma as a child/young person through: exposure to violence (such as in the cases of domestic and family violence) (Black, Woodworth, Tremblay, & Carpenter, 2012), being a child/young person victim of domestic and family violence, or a direct victim of abuse is commonly referred to as developmental trauma or complex trauma (Bollinger, Scott-Smith, & Mendes, 2017; Ford & Courtois, 2009; Price-Robertson et al., 2013; Teicher et al., 2004; Van der Kolk et al., 2009).

While traumatic experiences can have serious consequences for adults, trauma that occurs in early childhood, particularly that of a sustained or chronic nature, has been found to be even more profoundly damaging (Perry, 2006; Schore, 2001; Van der Kolk et al., 2009) because it fundamentally interferes with normal child development (Perry, 2006).

The impact of traumatic events on children and young people's cognitive, emotional, psychological and social development is well-documented (Perry, 2009; Schore, 2001; Van der Kolk, 2014). Complex trauma affects the developing brain and may interfere with a child/young person's capacity to integrate sensory, emotional and cognitive information, which may lead to over-reactive responses to subsequent stress, with the child or young person experiencing a prolonged overwhelmed emotional state (Milot, St-Laurent, & Éthier, 2016). This can lead to long-term negative effects (National Scientific Council on the Developing Child, 2007; Perry, 2001; Streeck-Fischer & van der Kolk, 2000), including on the child or young person's ability to relate to others and their adaptive reactions to experiences often becoming problematic for them (Price-Robertson et al., 2013).

Neglect and deprivation experienced by a child or young person will also have a significant impact on their development. These deleterious impacts will often differ according to the neglect sub-type (physical, emotional, supervisory, educational and medical neglect) and will be unique for each child/young person. However, current research suggests that, *the damaging effects of neglect are at least as harmful if not worse than other forms of maltreatment, including physical and sexual abuse* (NSW Family and Community Services, 2017b). Relative to physically abused children, neglected children have more severe cognitive and academic deficits, social withdrawal and limited peer interactions, and internalising (as opposed to externalising) problems (Hildyard & Wolfe, 2002). They will also experience learning difficulties and often have poor educational outcomes (NSW Family and Community Services, 2017a). Non-organic failure to thrive (decelerated or arrested physical growth associated with poor developmental and emotional functioning of a child usually under two years of age with no underlying medical cause) is also usually a result of neglect.

> Of all forms of maltreatment, neglect leads to some of the most profound negative long-term effects on brain and other physical development, behaviour, educational achievement and emotional wellbeing. (Stevenson, 2007, as cited in Daniel, 2015)

Childhood experiences of violence, abuse and neglect are well-documented risk factors for a number of adverse psycho-social outcomes. In addition to having a significant impact in childhood, the impacts of violence, abuse and neglect can affect a child/young person as they move into adulthood. Furthermore, having a parent who was subjected to violence, abuse and/or neglect as a child or young person increases the risk of one or all of these occurring in the next generation. These psycho-social impacts, long-term health impacts and impacts on future parenting are explored more in Appendix 1.

2.1.7 The issue of gender in child protection responses

Traditionally, child wellbeing was seen as the responsibility of mothers, with societal expectations of 'good mothers' setting a high standard for women (Fish, McKenzie, & MacDonald, 2009) in the child protection setting, and this expectation has continued. Humphreys & Asler (2011) and Humphreys, Healy & Mandel (2018) describe 'problematic' child protection interventions, based on the above assumptions, particularly when domestic and family violence is an issue, as: women being held to different standards than men and 'failing to protect' their children when domestic violence occurs, the invisibility or absence of the male abuser throughout the continuum of contact with

the family, the invisibility or minimisation of the existence of episodes of domestic violence (for example, describing them instead as “arguments” or “fighting” in case notes), and minimisation of violence (for example, describing strangulation, use of threats with weapons, and systematic isolation as “relationship problems”). Women are also often held responsible for attachment difficulties between the mother and child, which are often a result of deliberate strategies by the perpetrator to undermine the mother/child relationship. In addition, women are held more responsible where a child is being deprived of appropriate supervision, hygiene, nutrition, health care, shelter or education. CPCS counsellors need to be mindful of past practices with women and their children and look to preferred, evidence-based models of working with families (see also Section 6 and Appendix 7).

2.1.8 Resilience

There is considerable discussion in the literature regarding resilience factors that may help buffer children and young people from the full impact of their adverse experiences. The most consistent theme is the importance of access to positive relationships both within and external to the child/young person’s family. The presence of an attuned adult can scaffold and buffer a child/young person in the face of perceived and real threat.

Cultural connection and identity, particularly in Aboriginal communities, is recognised as a major resilience factor. Studies have found that people who strongly identified with their culture were buffered to some extent from experiences of trauma. “Culture plays a key role in how individuals cope with potentially traumatizing experiences by providing the context in which social support and other positive and uplifting events can be experienced” (DeVries, 1996, p. 400).

Working from a response-based practice framework can support honouring a child or young person’s resistance to the violence they have experienced and is a useful model in avoiding victim blaming (Richardson & Boonah, 2015).

2.2 Legislative and policy context

NSW Health counsellors operate within a broad range of NSW and Commonwealth legislation and provide services in response to violence, abuse and neglect involving children and young people in accordance with NSW Government (including NSW Health) and Commonwealth policy as well as national and international charters and conventions. Legislation, policies, charters and conventions of particular relevance are listed below and also provided at Appendix 4 alongside brief commentary on what they include.

2.2.1 Legislation

- *Children and Young Persons (Care and Protection) Act 1998 (NSW)*
- *Child Protection (Working with Children) Act 2012 (NSW)*
- *Crimes Act 1900 (NSW)*
- *Crimes (Domestic and Personal Violence) Act 2007 No 80 (NSW)*
- *Commonwealth Crimes Act 1914*
- *Evidence Act 1995 (NSW)*
- *Family Law Act 1975 (Commonwealth)*

- *Guardianship Act (NSW)*
- *Health Records and Information Privacy Act 2002 (HRIP Act) (NSW)*
- *Mental Health Act 2007 (NSW)*
- *Ombudsman Act 1974 (NSW)*
- *Privacy and Personal Information Protection Act 1998 (PPIP Act) (NSW)*
- *Victims Rights and Support Act 2013* (NSW).

2.2.2 Policies

- *Child Wellbeing and Child Protection — NSW Interagency Guidelines*
- *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*
- *Domestic Violence — Identifying and Responding*
- *NSW Health Privacy Manual for Health Information*
- *Photo and video imaging in cases of suspected child sexual abuse, physical abuse and neglect*
- *Subpoenas*
- *Your Health Rights and Responsibilities*
- *National Framework for Protecting Australia's Children 2009-2020*
- *National Plan to Reduce Violence against Women and their Children 2010-2022*

2.2.3 Charters and Conventions

- *NSW Charter of Victims Rights*
- *NSW Code of Practice for the Charter of Victims Rights*
- *Australian Charter of Healthcare*
- *United Nations Convention on the Rights of The Child*

2.3 Interagency context

The *NSW Children and Young Persons (Care and Protection) Act 1998* (the *Care Act*) provides the legislative framework for partnership and shared responsibility to maximise appropriate responses and assistance to families for the safety, welfare and wellbeing of children and young people. Section 245E of the *Care Act* requires government and non-government agencies, in order to effectively meet their responsibilities in relation to the safety, welfare or wellbeing of children and young persons, to take reasonable steps to coordinate decision-making and the delivery of services regarding children and young persons. Section 245A of the *Care Act* includes as a guiding principle that those agencies should work collaboratively in a way that respects each other's functions and expertise.

Government agencies besides NSW Health with particular responsibilities in these areas include:

- Department of Family and Community Services, which undertakes risk, safety and needs assessments and interventions for children or young people and families to ensure their safety, welfare and wellbeing.
- NSW Police Force, which conducts criminal investigation of allegations of violence, abuse and neglect matters involving children, including child abuse and neglect and domestic and family violence.

- Office of the Director of Public Prosecutions, which conducts criminal and related proceedings with respect to violence, abuse and neglect matters involving children and young people.
- Victims Services, which provides support, information, referrals, counselling and compensation services to victims of violent crimes and witnesses to violent crimes.
- NSW Department of Education, which protects young children by regulating preschool and long day care providers; provides children and young people with primary and secondary education through which staff have a duty to recognise and respond to safety, welfare or wellbeing concerns; and works to advance the wellbeing of Aboriginal people.

Local procedures and protocols for responding to violence, abuse and neglect must comply with centrally determined interagency guidelines for government agencies, including:

- *Child Wellbeing and Child Protection — NSW Interagency Guidelines*.
- Joint Child Protection Response Program (formerly JIRT) interagency policy and procedures and local planning and response procedures.
- *NSW Charter of Victims Rights.*
- *Memorandum of Understanding between NSW Health and FACS on Health Screening, Assessment, Intervention and Review for children and young people in Out-of-Home Care*.

To respond effectively to children, young people and families/carers who have experienced trauma, a coordinated service response is required. To achieve this, CPCS works in coordination with the government agency partners listed above, other health service providers, and in collaboration with other interagency partners, including Aboriginal and non-government organisations (NGOs) providing out-of-home care (OOHC).

3 Framework for effective practice

This section provides a summary of: the principles underpinning CPCS, child safe organisation requirements, and key shared theoretical concepts.

More detailed information about the specific theoretical frameworks and practice approaches underpinning CPCS practice are provided in Appendices 6, 7 and 8.

3.1 Principles underpinning CPCS

The principles which reflect the values and underlying philosophy of CPCS practice include:

- To deliver on the promise of genuine respect, dignity, and choice in all aspects of the work.
- To be person-centred in attitude and practice, understanding diversity of identity and need, where the individual is at the centre, as they inform assessment and practice.

- To prioritise working towards safety from harm, violence, abuse and neglect for the child/young person and all of their family members (including parents and other children/young people).
- To accept that safety shifts and that children/young people and supportive adults may not yet be safe when first establishing engagement and goals.
- To be authentic in partnership with the child/young person, family and carers, and referral service, with the aim of developing a shared understanding of the problems, goals and ways to achieve those goals.
- To recognise the power of culture and, through partnership with the community, seek out its role in healing. To appreciate that one cannot be an expert on another person's life.
- To remain open and willing to reflect on, and critique one's own judgement, and encourage others to do so.
- To build and sustain collaborations with other services.
- To accept responsibility for engaging children/young people and families and carers, even when they have reason not to trust others.
- To gather information for purpose.
- To create opportunities for small or big change and celebrate signs of hope.

These principles are to be found throughout each phase of CPCS involvement.

3.2 Child safe organisation requirements

The United Nations Convention on the Rights of the Child obliges institutions providing services to children to act in the best interests of the child as their primary consideration. In response to recommendations made by the *Royal Commission into Institutional Responses to Child Sexual Abuse* (the Royal Commission), NSW Health has affirmed its commitment to ensuring that *all* its services, including those whose primary clients are adults, uphold the rights of children and are 'child safe'.

All CPCS, with support from Local Health Districts, are expected to promote and facilitate child safety within their organisational context through implementation of the Principles for Child Safe Organisations, outlined below.

A 'child safe organisation' is one that takes deliberate steps to create and embed workplace cultures, adopt strategies and take actions to promote child wellbeing and prevent harm to children and young people. More specifically, a child safe organisation is one that:

- Creates an environment where children's safety and wellbeing is the centre of thought, values and actions.
- Places emphasis on genuine engagement with and valuing of children.
- Creates conditions that reduce the likelihood of harm to children and young people.
- Creates conditions that increase the likelihood of identifying any harm.

- Responds to any concerns, disclosures, allegations or suspicions of harm (Australian Human Rights Commission, 2018, p. 3).

The *National Statement of Principles for Child Safe Organisations* (the Principles) incorporate and are underpinned by the 10 Child Safe Standards identified by the Royal Commission, and are designed to be 'high level' and flexible enough to support localised implementation and recognise the range of organisational types, sizes and capacities. More detail about the principles and how these should be applied by CPCS in practice is provided in Appendix 5.

3.3 Key approaches and theoretical concepts underpinning CPCS practice

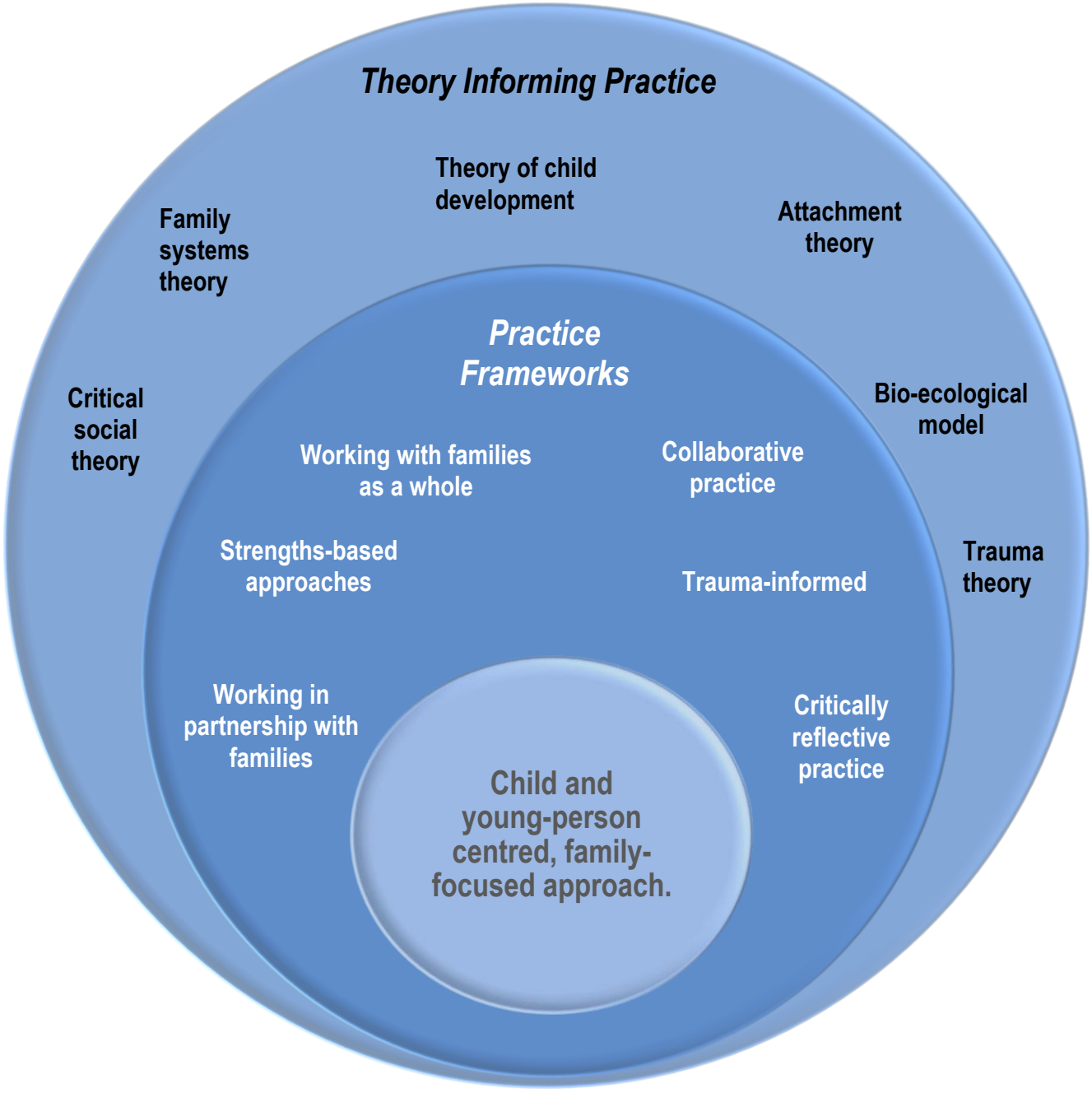
It is critical that practice with vulnerable families, children and young people is guided by sound theoretical underpinnings, which are often seen as the formal knowledge base for practice. Through the use of theory, practitioners can work in inclusive and anti-oppressive ways with children and young people, resisting practice which is based on assumptions and stereotypes (Collingwood, Emond, & Woodward, 2008).

Key theories that are useful in guiding practice with families, children and young people include:

- The bio-ecological model of human development.
- Child development theory.
- Attachment theory.
- Trauma theory.
- Family systems theory.
- Critical social theory.

The diagram below illustrates the key theoretical concepts underpinning CPCS practice and key practice approaches. Further detail on these is provided in Appendices 6 and 7.

Figure 3: CPCS theoretical underpinnings and practice approaches



Part Two: Responding to violence, abuse and neglect involving children

4 Overview of the Child Protection Counselling Services service model

Violence, abuse and neglect involving children and young people can result in trauma which undermines a child/young person's safety, health and wellbeing, especially in the absence of protective and positive caregiver relationships. Restoring safety is the first step to recovery. In collaboration with other services, Child Protection Counselling Services (CPCS) support the child/young person in establishing safety and recovery from trauma while working to help the family address risk factors and build upon their strengths. When this is not possible or sufficient to ensure the child/young person's safety or wellbeing, CPCS supports the child/young person through the recovery process while in the care of others. In these circumstances CPCS works with the carers of the child/young person to establish the best environment for their health and wellbeing, while also retaining a focus and, where possible, a connection with the child/young person's family and/or next of kin.

CPCS aim to increase safety and reduce trauma by tailoring interventions to each child/young person and family/carer, which are underpinned by the following common objectives:

- Work with interagency partners to reduce current risks for the child/young person to ensure they are living in a safe and nurturing environment free from violence and neglect.
- Increase the capacity of parents and/or carers to:
    - understand impacts of violence, abuse and neglect on the child/young person; and
    - meet the specific needs of the child/young person.
- Ameliorate the impacts of violence, abuse and neglect for the child/young person.
- Increase stability and opportunities for the child/young person's optimal development and wellbeing.
- Work collaboratively with interagency partners to facilitate access to appropriate services in a timely and consultative manner.

To achieve these objectives, CPCS undertake consultation, engagement and assessment and develop goals and a therapeutic service plan for each child/young person and referred family members/carers. This occurs in collaboration with the child/young person, their family/carers, referrers, and/or other relevant service providers. After assessment and planning, interventions may involve, but are not limited to:

- establishing safety;
- providing information and support;
- therapeutic interventions (e.g. counselling, play therapy, family therapy, group work);

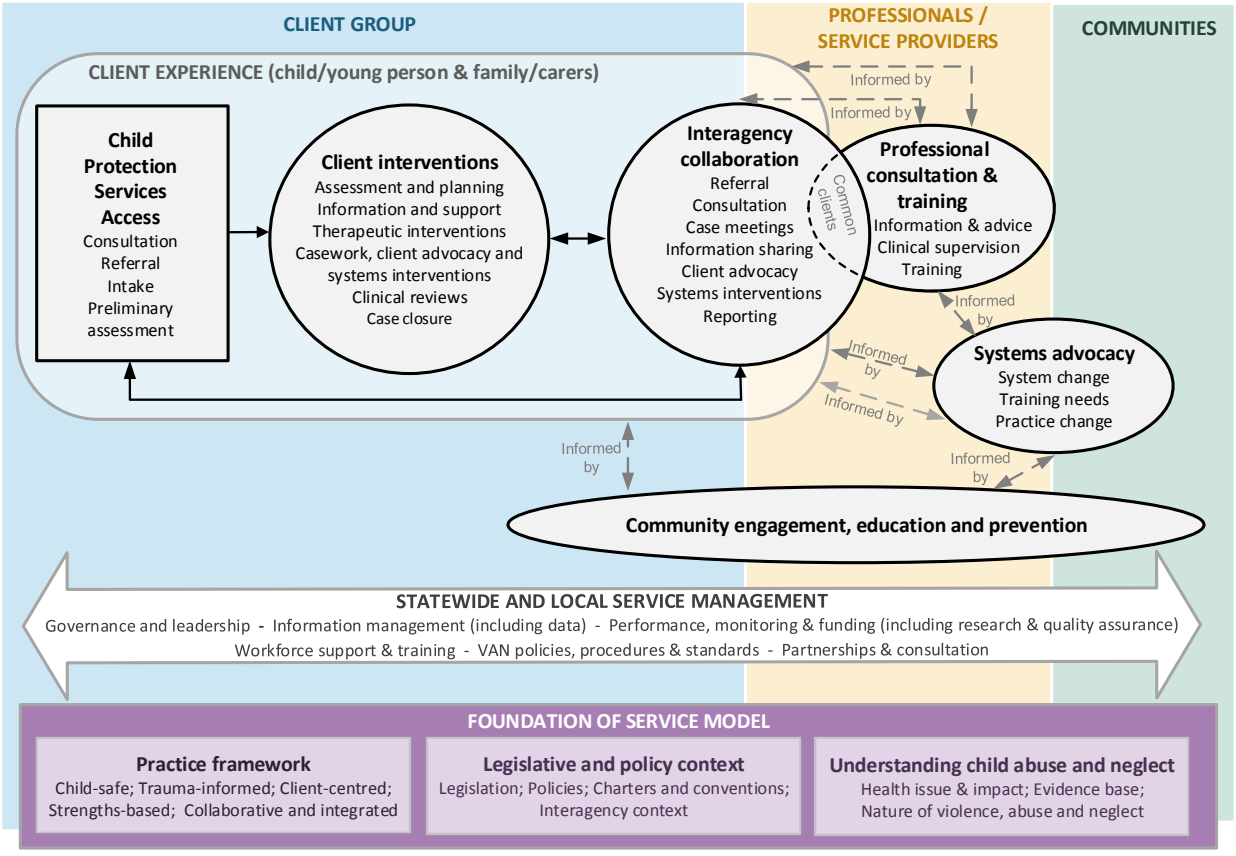
- casework, client advocacy, and systems interventions;
- clinical reviews; and
- case closure.

In addition to this range of interventions with children/young people and families/carers, CPCS provides systems support and change through activities including violence, abuse and neglect-related:

- professional consultation and training;
- systems advocacy; and
- community engagement, education and prevention activities.

The CPCS service model incorporating all of these elements is represented in Figure 4 below. Although these elements are represented in discreet conceptual categories to help make sense of the role of CPCS and activities within this role, these elements and activities often overlap in practice.

Figure 4: Service Model — Child Protection Counselling Services



4.1 Summary of key elements of Child Protection Counselling Services

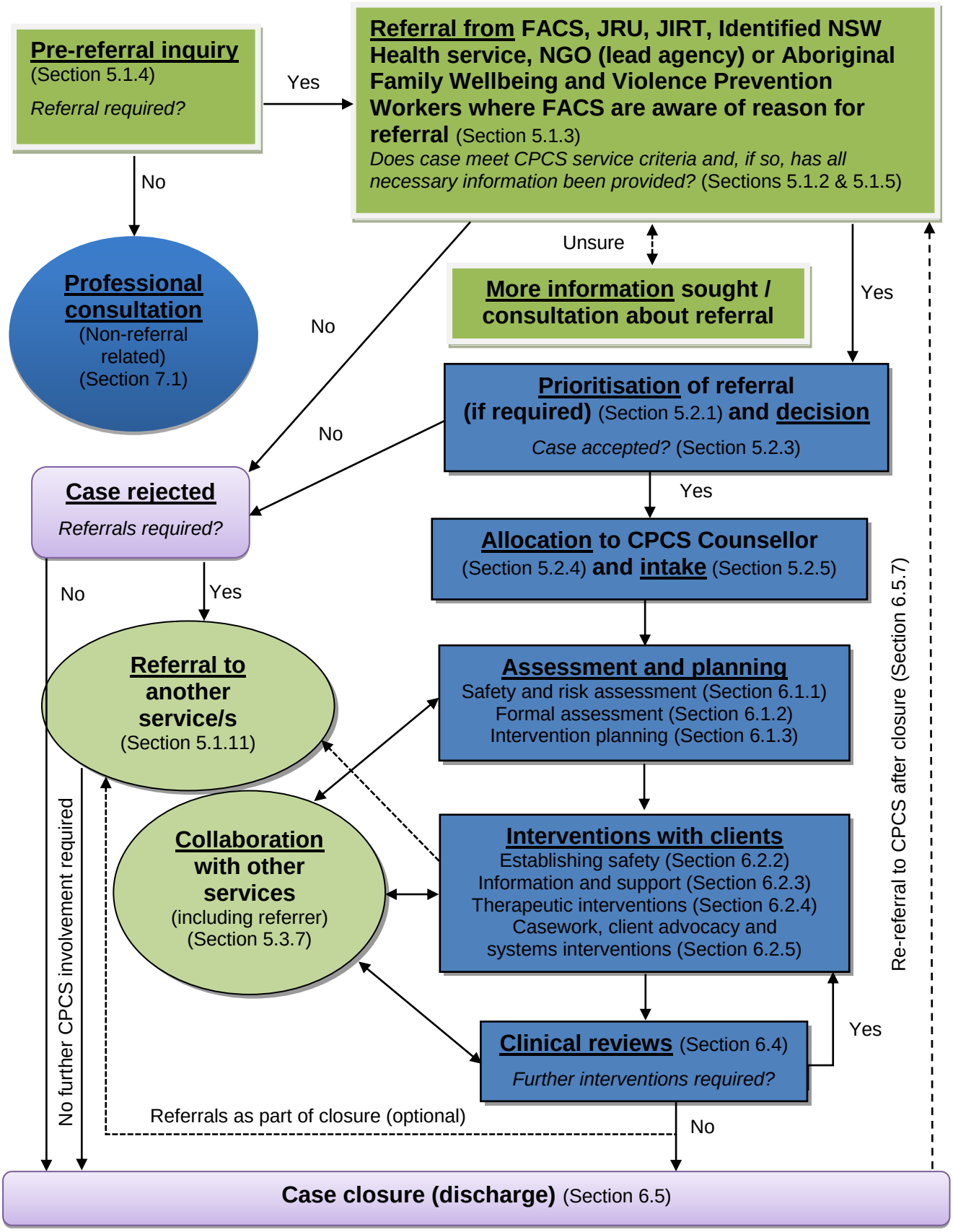
Table 1 below provides a summary of the key elements of the CPCS that are further detailed in the remainder of these Policy and Procedures.

Table 1: Key elements of Child Protection Counselling Services	
Key elements	Description
Governing structures	CPCS are NSW Health services managed by and within each of the NSW Health Local Health Districts (LHDs). The NSW Ministry of Health sets the policy direction and service standards, provides clinical practice guidance and monitors service outcome targets for these services.
Service aims	CPCS aims to help children/young people recover from violence, abuse and/or neglect and support them to achieve safety, security and stable living arrangements to: • stay with their family (family preservation); or • return to live with their family (family restoration); or • remain in their current placement, or move to a more sustainable placement (placement stability). As such, CPCS focuses on the children/young people and their family/carers.
Client group	Children/young people and families/carers impacted by violence, abuse and/or neglect. Age ranges from infancy to adolescence (0-<18 years). Children/young people may be living with parents or with extended family/kin or in out-of-home care. Family members such as one or both parents are considered clients of CPCS where the referral goals directly relate to them.
Responsibilities for violence, abuse and neglect (VAN)	CPCS is part of a network of NSW Health violence, abuse and neglect (VAN) services including Sexual Assault Services, New Street Services, Joint Referral Unit (JRU), Joint Child Protection Response Program (the Program), Domestic violence specialist services, and integrated VAN workers (see also Appendix 2). CPCS have primary responsibility for responding to: • physical and emotional abuse; • neglect; and • exposure to domestic and family violence. CPCS will also provide trauma-informed responses to their client group for other forms of violence, abuse and neglect involving children as follows: • Child sexual assault and children under 10 with problematic or harmful sexual behaviours where the child/young person is otherwise eligible for a CPCS response. • Domestic and family violence, adult sexual assault, and/or adult survivors of child sexual assault where these experiences are impacting on the capacity of the family/carers to provide the safety or support required to meet the child/young person's needs. In this work CPCS is guided by relevant NSW Health policy including, but not limited to: *Sexual Assault and Children under 10 with Problematic or Harmful Sexual Behaviours Policy and Procedures* (in development) and

Table 1: Key elements of Child Protection Counselling Services	
Key elements	Description
	Domestic Violence — Identifying and Responding. CPCS may also consult and/or collaborate with other NSW Health VAN services, such as Sexual Assault Services or Domestic Violence Services, where these secondary presenting VAN issues arise.
Referrals	Referrals are made to CPCS by: • Family and Community Services (FACS) through the local Community Service Centre (CSC). • Joint Referral Unit (JRU) or Joint Child Protection Response Program (the Program) via the JRU/the Program Health worker. • Non-government organisations (NGOs) providing OOHC case management or family preservation services (lead agency) where FACS or JRU/the Program are aware of the reason for the referral in accordance with the requirements in Section 5.1.2. • NSW Health services including Child Protection Units, Out of Home Care (OOHC) Health Pathway Program, Sustaining NSW Families, Whole Family Teams, Child and Adolescent Mental Health Service, Sexual Assault Services, New Street Services, and other appropriate NSW Health services identified by each CPCS for their local area where FACS or JRU/the Program are aware of the reason for the referral in accordance with the requirements in Section 5.1.2. • Aboriginal Family Wellbeing and Violence Prevention Workers (working under the NSW Health *Aboriginal Family Health Strategy*) where FACS or JRU/the Program are aware of the reason for the referral in accordance with the requirements in Section 5.1.2.
Multidisciplinary team structures	• Clinical staff employed with a range of disciplines including (but not limited to) Social Work, Psychology, Counselling, Occupational Therapy, Speech Therapy, Aboriginal Health Education Officers and Aboriginal Health Workers. • Local service provision across the state by teams within the Local Health District. • Some teams are located in one site and others are spread out across the Local Health District. • Line management supervision and clinical supervision is provided within the Local Health District, but may be supplemented by external supervision.
Client service delivery model	Phases of intervention begin with consultation, referral, intake, engagement and assessment, planning and implementation of tailored interventions with children/young people, families/carers and their broader support networks, followed by review and then closure. Interventions range from short-term (e.g. three to six months), medium-term (e.g. six to 12 months) or long-term (e.g. beyond 12 months). Average duration of service is approximately 12 months.

Table 1: Key elements of Child Protection Counselling Services	
Key elements	Description
Conceptual base	Evidence-based practice and research-informed interventions tailored to the child/young person's needs and developmental stages, the family/carers' needs and readiness for change, and the level and type of risk. Therapeutic interventions are trauma and attachment-informed within a developmental and ecological perspective, including the importance of culture.
Modes of intervention	Following intake, assessment and planning interventions include: establishing safety; provision of information and support; casework, client advocacy and systems intervention; and a range of therapeutic interventions such as individual therapy with children/young people, dyadic work with children and parents/carers, family work, child-focused work with parents/carers, and group work. Interventions may occur in the child's home, placement, school, CPCS office or other appropriate site. At different points in the intervention, a review and potentially a re-focus of the goals and intervention plan will need to occur or will be followed by case closure when appropriate.
Systems support and change	CPCS provides services concerning systems support and change concerning violence, abuse and neglect involving children, including: • professional training and consultation to Health, FACS, NGOs and other services in the community; • systems advocacy; and • community engagement, education and prevention.

4.2 Overview of the CPCS client services pathway (Figure 5).



5 Service access

5.1 Referral

5.1.1 Overview

Child Protection Counselling Services (CPCS) accept referrals for children/young people and their families/carers where there has been violence, abuse and/or neglect, and there is a perceived need for a trauma-specific service to contribute to their safety, welfare and wellbeing. This section describes the referral and intake process across all CPCS sites.

The aim of referrals to CPCS may include one or more of the following:

- to enable the child/young person to recover from harms resulting from violence, abuse and/or neglect; AND
- enable the family to understand and respond effectively to the child/young person's needs in order to prevent further harm and to support the child/young person to remain or return to the family's care; OR
- enable carers to understand and respond effectively to the child/young person's needs in order to prevent further harm and help prepare the child/young person to make the transition from out-of-home care to family, or to support the placement to be more sustainable.

5.1.2 Service criteria

Referrals may be made to CPCS for any child/young person up to the age of 18 years (including prenatal referrals) and/or their families/carers residing in NSW:

- who has been subjected to violence, abuse and/or neglect by a parent/carer and where there is a plan for family preservation, family restoration or for the child to remain in Out of Home Care (OOHC); OR
- for whom the referrer has identified through a clinical assessment and consultation with interagency partners including Family and Community Services (FACS) that the child/young person may have been physically or emotionally abused or neglected or exposed to domestic and family violence; AND
- where a specialist (tertiary) clinical intervention is required to contribute to the child/young person's safety, welfare and wellbeing.

To help ensure their safety and the appropriate targeting of CPCS, a child/young person can only be referred to a CPCS by one of the referral sources other than FACS or JRU/the Program (see Section 5.1.3) if FACS or JRU/the Program are aware of the reason for the referral. This at a minimum requires that a report about the specific incident, behaviour or circumstances the child/young person is being referred to CPCS for (or a duplicate report by another reporter) has been:

- screened in by the Child Protection Helpline as 'Risk of Significant Harm' (ROSH);

- or forwarded to a FACS Community Services Centre for information, since it refers to an open FACS matter (i.e. the child/young person has already been assessed as at ROSH and allocated to a caseworker).

'Substantiation' by FACS that the child/young person has been subjected to violence, abuse and neglect is not required to be eligible for CPCS. The Health role is to focus on the ongoing safety, health and wellbeing of the client and those around them and not 'what happened'. Clinical need based on a clinical assessment, rather than substantiation or confirmation of abuse, is therefore the key criteria for referral and entry to a CPCS.

5.1.3 Referral sources

Referrals to CPCS may be received from:

- Family and Community Services (FACS) through the local Community Service Centre (CSC).
- Joint Referral Unit (JRU) or Joint Child Protection Response Program (the Program) via the JRU/the Program Health worker.
- Non-government organisations (NGOs) providing OOHC case management or family preservation services (lead agency) where FACS or JRU/the Program are aware of the reason for the referral in accordance with the requirements in Section 5.1.2.
- NSW Health services including Child Protection Units, Out of Home Care (OOHC) Health Pathway Program, Sustaining NSW Families, Whole Family Teams, Child and Adolescent Mental Health Service, Sexual Assault Services, New Street Services, and other appropriate NSW Health services identified by each CPCS for their local area where FACS or JRU/the Program are aware of the reason for the referral in accordance with the requirements in Section 5.1.2.
- Aboriginal Family Wellbeing and Violence Prevention Workers (working under the NSW Health *Aboriginal Family Health Strategy*) where FACS or JRU/the Program are aware of the reason for the referral in accordance with the requirements in Section 5.1.2.

5.1.4 Pre-referral consultation

CPCS facilitates access to the service and supports collaboration with interagency partners through consultation. Consultation is a key element of the service provided by CPCS and contributes to the safety and wellbeing of children in general, not just the CPCS client group.

The CPCS consultation processes with referrers assist case managers with three tasks:

- Triage of potential referrals to CPCS.
- Active pre-referral assistance, including clarification of the reason for referral, ensuring the referral is appropriate for CPCS, support around the completion of the referral process, and identifying proposed outcomes from the CPCS referral.

- Secondary consultation concerning the clinical needs of a child/young person or family regardless of whether or not there is a referral to the CPCS (see also Section 7.1).

A partnership agreement should be established and maintained between CPCS and relevant referral sources (see Section 5.1.3). This would include a commitment to regular liaison or consultation meetings or contact between CPCS and the referring agencies as these enable each stakeholder to have up-to-date knowledge regarding possible referrals and CPCS capacity. Arrangements for establishing and maintaining these partnerships will vary according to the local area and available services. However, the CPCS manager or clinical lead should complete a partnership agreement outlining:

- The type of consultation CPCS can provide.
- The process for accessing consultation.
- Advice as to records of any consultations maintained by CPCS.
- Advice as to the circumstances under which a CPCS counsellor may seek further advice or respond to protective concerns.
- Any meetings that will occur as part of the consultation partnership.
- A process for resolving disagreements.
- A time and process for reviewing the agreement.

5.1.5 Referral process

CPCS will ensure there is a clear system for receiving referrals and a contact person for the management of referrals and enquiries wherever possible. When the CPCS counsellor is a sole CPCS counsellor at a site, a plan that suits the local context will be devised by the CPCS manager or clinical lead and communicated with all likely referrer organisations. This plan may nominate the CPCS manager, clinical lead, another identified CPCS service, or the local counsellor as the contact person, depending on what is considered most viable.

Following a preliminary discussion between the referrer and CPCS contact person to determine the appropriateness of the referral, a standard CPCS referral form is completed. There is one referral form and referral number per family. This form may be submitted by email and is signed by the Family and Community Services (FACS) Caseworker and Manager or other referrer as appropriate.

Provision of the following information during the referral is useful for decision-making regarding acceptance and case allocation and to inform the CPCS assessment and plan:

- The reason for the referral and behaviours and/or circumstances the referrer wants to change and why.
- Confirmation of advice that the referrer has received feedback from the Child Protection Helpline that the specific incident, behaviours or circumstances the child/young person is being referred to CPCS for have been screened in by the Helpline as ‘Risk of Significant Harm’ (ROSH) or forwarded to a FACS Community

Services Centre for information since the latter refers to an open FACS matter (and thus the new information is not 'screened in' at the Helpline). This only applies where the referrer is not FACS or JRU/The Program.

- The child/young person's and family/carers' developmental and risk history, current functioning, risks, strengths, and needs.
- The involvement, role and contact details of other services working with the child/young person and family/carers.

All relevant documents should be forwarded to CPCS at the time of referral. This may include, for example:

- A copy of a current FACS Safety Assessment and Risk Assessment (and Risk Reassessment) (SARA).
- Previous Children's Court action and/or other court reports.
- Initial assessments, secondary assessments and reports by clinicians or agencies that are working with, or have worked with, the child/young person and/or family/carers.

Information shared must be in accordance with information exchange provisions within the *Children and Young Person's (Care and Protection) Act 1998*. Information-sharing is discussed in further detail in Section 9.2.

For referrals regarding Aboriginal children/young people and families/carers, the referrer may have already liaised with Aboriginal Family Health Workers or other Aboriginal organisations to ensure the cultural needs of the child and family are considered. If this has not occurred, CPCS will consult with the relevant Aboriginal organisation or adviser during the referral process to ascertain their views about the referral and the proposed plan. This is in keeping with NSW Health's commitment to partnering with Aboriginal people to support their self-determination in decisions about Aboriginal individuals, families and communities (NSW Ministry of Health, 2012).

For referrals regarding children/young people and families/carers from culturally and linguistically diverse backgrounds, the referrer should provide information regarding relevant cultural and language considerations. This may include cultural identity, whether or not an interpreter is required, cultural connections, practices and obligations, and the possibility of an appropriate cultural consultant.

Children in out-of-home care are to be referred to CPCS via the Community Service Centre (CSC) (whether the originating referrer is the CSC or the NGO). The FACS policy is that such referrals require the approval of a FACS psychologist. The referrer should seek this approval and note it on the referral form.

If the situation is particularly complex or there are significant concerns about the child/young person's risk and safety, CPCS will request a case conference with all relevant services, including FACS, to fully discuss the child/young person's current safety and the proposed plan. If there is disagreement regarding whether or not the child/young

person's situation in terms of risk and safety indicates CPCS is not an appropriate service or certain CPCS interventions are not appropriate at that time, then the usual dispute processes between CPCS and the referrer should be enacted to clarify and resolve any differences to arrive at a clear decision.

During the process of referral there should be clarification about the plan for ongoing involvement of the referring service with each child/young person and other members of the family. The CPCS (along with any other significant services involved) will discuss and negotiate the role of each service in supporting the family/carers to increase safety and to formulate a plan for appropriate timeframes for service withdrawal that does not compromise a child/young person's safety or a family/carers' workability.

5.1.6 Referrals where violence, abuse or neglect is not substantiated

As noted above, substantiation of violence, abuse and neglect involving children is not necessary for referral to a CPCS. Where a matter has not been substantiated[4] (for example where a child/young person has not disclosed during a Joint Child Protection Response Program (the Program) interview, the child is not interviewed, the matter does not reach the threshold for the Program, or the matter is not being further investigated by the Program or FACS for any other reason), the referrer, for example a JRU Health worker, may determine that a referral to CPCS is indicated based on a clinical assessment. This assessment should be based on information including, but not limited to:

- Disclosure by the child/young person of physical or emotional abuse, neglect or exposure to domestic violence to another person outside of the FACS/the Program processes (e.g. parent, teacher, or trusted adult).
- The child/young person presents with active trauma symptoms (e.g. emotional distress, unexplained changes in functioning/behaviours, intrusive cognitions, nightmares, hyper-vigilance, poor appetite, depression, anxiety).
- Credible witness to the violence, abuse or neglect involving the child/young person (e.g. another parent).
- A request to the referrer for support from a Child Protection Counselling Service from the family/carers of the child.

In these circumstances, however, and where the referrer is not FACS or the Program, the incident, behaviours or circumstances the child/young person is being referred to CPCS for must still have been screened in by the Child Protection Helpline as 'Risk of Significant Harm' or the information has been forwarded by the Helpline to a FACS Community Services Centre (since it refers to an open FACS matter) (see Section 5.1.2).

[4] Substantiation refers to where FACS has conducted an investigation and concluded there is reasonable cause to believe that the child had been, was being, or was likely to be, abused, neglected or otherwise harmed (Australian Institute of Family Studies, 2017).

5.1.7 Referrals regarding sexual assault and children under 10 with problematic or harmful sexual behaviours

If a referral for a child/young person meets the service criteria for CPCS (see Section 5.1.2) and there are also concerns regarding the child/young person having experienced sexual assault and/or where the referral is for a child under 10 with problematic or harmful sexual behaviours, discussions should occur between the referrer, CPCS and the relevant NSW Health Sexual Assault Service to determine which is the most appropriate service to accept the referral. For example, if the primary goal is to support family preservation, restoration or sustainability of placement, then CPCS may be the most appropriate service. If the primary goal of referral is to help the child recover from the experience of sexual assault and/or address the problematic or harmful sexual behaviour (where the child is under 10 years old), then the Sexual Assault Service is likely to be more appropriate.

As NSW Health trauma-informed, violence, abuse and neglect services, both CPCS and Sexual Assault Services should provide skilled responses to the secondary presenting violence, abuse and neglect issues and, where necessary, should consult with their colleagues from the other service for information and advice on that secondary presenting issue. There may be occasions where both services are involved with the one child/young person and family/carers; in which case clear agreement of each service's roles and activities should be documented and regularly reviewed.

5.1.8 Referrals regarding children and young people 10-17 years old with sexually harmful behaviours

NSW Health policy requires that no NSW Health service may treat young people 10-17 years old for their sexually harmful behaviour other than New Street Services. When a child or young person 10-17 years old with sexually harmful behaviours is referred to a CPCS, discussions should occur between the referrer, CPCS and New Street as to the nature of the behaviour and which is the most appropriate service, or if referral to a third service is more appropriate.

In exceptional circumstances and where there is no New Street service available or no other more appropriate service to refer to in that area, CPCS may choose to accept a referral for a child/young person 10-17 years who otherwise meets both CPCS and New Street service criteria, provided the CPCS:

1. Consults with a New Street and that New Street Manager/Coordinator approves the CPCS working with the client. This approval should be documented in the case file.
2. Where necessary (particularly where they have limited experience with this client group), the allocated CPCS counsellor is provided with information, advice and ongoing support (e.g. supervision) from New Street or another appropriately qualified worker with expertise in this field; AND.
3. The Local Health District Tier 2/3 manager responsible for the CPCS accepting the referral provides written approval that the CPCS may work with the child/young person and their family/carers. Consideration should also be given to

supporting the CPCS Team to access informal training with New Street to enhance their skills and knowledge of the New Street Practice Model.

5.1.9 Referrals of clients with two or more other presenting issues

If a referral for a child/young person meets the service criteria for CPCS (see Section 5.1.2) and there are two or more presenting issues that mean the child/young person could be eligible for other NSW Health services (apart from Sexual Assault Service or New Street Services already identified above), the CPCS counsellor should work with the referrer, family/carers and child/young person (where appropriate) to identify the primary presenting issue. Where it is difficult to isolate a primary presenting issue, it may be necessary for CPCS to consult with other NSW Health services and/or undertake joint intake processes/assessment to determine the most appropriate service to undertake the lead with that child/young person and what role, if any, the other service might play to support them (e.g. joint clinical work or information and advice to the lead NSW Health service on the secondary presenting issue). In cases were both services will work with the child/young person and family/carers, clear agreement on each services' roles and activities should be documented and regularly reviewed.

5.1.10 Transfers of cases between CPCS teams

To help ensure continuity of care in interventions and prioritisation of the child/young person's best interests, CPCS will endeavour to ensure continuity of care when a child/young person and/or family/carers move to a different geographical area. As children/young people and families involved in the care and protection system are at high risk of transience and unplanned transitions, CPCS recognises its responsibility to minimise disruption of service wherever possible.

Where possible the current CPCS team will maintain clinical responsibility and the ongoing role with the child/young person and family/carers. This is particularly important if the history or the plan suggests the child/young person is likely to move again.

When it is not possible or not the best plan for the current CPCS team to remain involved, but further CPCS intervention is warranted, a decision regarding transfer to a new CPCS team must occur in a timely and collaborative way. This discussion should be between the two relevant Community Service Centre offices or other referrer/relevant service (as applicable) and the two CPCS teams.

The *NSW Health Privacy Manual for Health Information* notes that privacy laws allow a Health Service to disclose personal health information to another Health Service involved in the ongoing care of the client provided the client has a 'reasonable expectation' this will occur. Providing information to clients about what will happen with their information ensures compliance with privacy laws. It is also good clinical practice for clients to be included in decisions regarding the use and disclosure of their personal information.

All available and relevant information will be provided to the new CPCS team to minimise disruption, maximise potential to continue working on goals and to reduce potential for increased risk. The new CPCS team will be provided with a copy of the original referral form, relevant reports received during the course of the original referral (e.g. psychosocial

reports, developmental assessments) and any other reports. There must also be an opportunity to view the file, where this is required and practicable.

If the new CPCS does not have capacity to allocate the case immediately then the current CPCS team will maintain involvement and the new CPCS team will prioritise this transfer for the next available vacancy. If it is unlikely there will be capacity within the new CPCS team in the foreseeable future and it is unworkable for the current CPCS team to continue to see the child/young person and family/carers, then alternate referrals will need to be considered. This will be discussed with the Community Service Centre, relevant NGO, referrer, or other relevant service as appropriate.

Once the referral to the new CPCS has been accepted, at least one handover session will take place with the child/young person and family/carers and with other services involved. This may occur within one meeting or held as separate meetings. Where possible, the current and new CPCS counsellors will meet together with the child/young person and their family/carers to discuss the transfer plans and to facilitate engagement with the new counsellor.

5.1.11 Referrals to other services

CPCS may need to provide referrals to other services, agencies or professionals to ensure a child/young person and their family/carers have access to a range of service responses and assistance that is trauma-informed and most appropriately suited to their needs. Such referrals may take place at any stage of referral, intake, and through the various interventions and service responses CPCS provide through to case closure. Although referral to other services is addressed here in the section on service access, the information provided is therefore applicable across the scope of CPCS service delivery.

A referral may be to provide an appropriate service response to the client in collaboration with the CPCS response or instead of it in circumstances where a child/young person's or their family/carers' needs would better be met wholly by a different service. When the CPCS is making a referral, client information will be treated with respect and confidentiality. CPCS will develop formal protocols and procedures to ensure appropriate and efficient outgoing and trauma-informed referral processes. Written procedures for referrals will cover issues of consent, confidentiality and, where appropriate, feedback on the outcome of the referral**.**

In providing referrals and developing referral protocols and procedures, CPCS will adhere to:

- The NSW Health *Privacy Manual for Health Information*.
- The *NSW Charter of Victims' Rights Code of Practice* to help ensure victims of crime access their entitlements under the NSW Victims Support and Rights Act 2013.
- NSW Health's *Conflicts of Interest and Gifts and Benefits* policy.
- Information-sharing provisions in the *Children and Young Persons (Care and Protection) Act 1998* and *Crimes (Domestic and Personal Violence) Act 2007* where consent is not provided (see Section 9.2 for further information).

CPCS should approach referrals in a proactive way: for example, by providing 'warm' referrals for clients and actively following up on referrals and their outcomes. CPCS should work collaboratively with agencies/professionals they refer to where both are providing a service to the same client or family. In some circumstances, CPCS counsellors may need to adapt their service responses in consultation with the agency they are referring to as appropriate. For example, where a child/young person attending counselling develops acute mental health issues requiring hospitalisation or psychiatric care, the CPCS may refer to a Child and Adolescent Mental Health Service (CAMHS) and then work collaboratively with them to continue providing support, such as through casework with the child/young person and family/carers and/or professional consultation with the CAMHS on responding to violence, abuse and neglect involving children (see Section 7.1) until the child/young person is ready to re-engage in counselling. The same would apply to working with drug and alcohol services.

Referrals to private practitioners

CPCS will ensure that any referrals for clients to private practitioners are made in a professional and consistent manner and ethical considerations are addressed where CPCS staff have a private practice in the same geographical area as the CPCS.

When referring potential clients to private practitioners, CPCS must comply with the NSW Health Policy Directive *Conflict of Interest and Gifts and Benefits*. This includes: presenting all relevant information when recommending providers (both public and private); providing a rationale for the recommendation (including location, cost and cultural appropriateness); and providing the client with information about the service and any relevant peak bodies.

CPCS counsellors who are also private practitioners are not to include themselves in this list of names. The *NSW Health Code of Conduct* can also provide further guidance on this issue.

5.2 Intake

5.2.1 Prioritisation of referrals

Principles for prioritisation

When CPCS receives a higher demand of eligible referrals than it has capacity to accept, prioritisation of referrals needs to occur based on a transparent, consistent, albeit flexible and needs-based process. The prioritisation of referrals occurs in partnership with the referrer and other services supporting the children/young people and their families/carers.

Children/young people and families/carers with the highest clinical need are given priority.

CPCS will consider the following factors in the assessment of clinical need:

- Living with biological parents or in kinship care with current risk of significant harm issues.
- Severity of impacts of trauma on daily functioning of child.

- Age and developmental maturity.

CPCS will not prioritise according to the date the referral was received, but rather will assess clinical need alongside families' capacity to engage in therapeutic interventions.

Prioritisation criteria

Where there are insufficient caseload vacancies for two or more referrals where clinical need is assessed as equal, a two stage process against identified priorities based on the reason for referral and vulnerability and risk will be followed as outlined below.

The first determination of priority relates to the reason for referral. The order of priority is as follows:

1. Children/young people living at home (or in kinship care) where there is risk of the child/young person being removed (family preservation).
2. Children/young people living in out-of-home care where there is a plan in the immediate to short-term for reunification (family restoration).
3. Children/young people living in out-of-home care where there are concerns that the placement is not able to provide safety and/or stability, or where another placement is considered more likely to provide security and stability, but the child/young person needs assistance to make the transition (placement sustainability).

A child/young person who is a client of another CPCS team but has moved into a different area is another priority for the CPCS team in the new area. The preferred plan is usually for the original CPCS team to maintain the case; however, if this is not viable (e.g. due to distance), then these referrals would be a priority for the new team (see Section 5.1.10).

If further prioritisation is required due to the capacity of the CPCS and comparable need and priority in two referrals, then the following factors will be considered. However, clinical assessment of safety concerns and needs should always take precedence as noted above:

1. Aboriginal children/young people.
2. Children under the age of 5 years old.
3. Serious physical or psychological injury as a result of physical abuse, neglect or domestic violence.
4. Where the parent/carer has co-existing issues affecting their capacity to keep the child/young person safe, e.g. substance use and dependence, mental illness, or disability.
5. Children/young people who are considered at greater likelihood of risk and where the harms are likely to be severe, e.g. previous death of the child in the family from non-accidental injury, multiple child protection reports, disability, chronic or serious illness, previous assumption of care or removal of the child or other siblings in the family, and/or recent separation of parents/carers in the context of domestic and family violence.

6. Children/young people who have recently experienced violence, abuse and neglect.

5.2.2 Waitlist

CPCS will not keep a waiting list due to the inherent uncertainties of a waiting list and the lack of clarity regarding who has clinical responsibility for that child/young person and their family/carers.

When the referral is considered eligible but there is not capacity to accept at that time, alternative suggestions will be offered. At each time when there is capacity to accept new referrals, the referrals will be considered on the basis of the clinical need and the prioritisation criteria (see Section 5.2.1) at the time and not on whether this child/young person has been previously referred.

If the referrer, such as Family and Community Services (FACS) or an NGO, wishes to keep a list of cases they may refer to CPCS for the next vacancy, that is their decision and it is their responsibility to monitor that list.

CPCS will keep record of the unmet need for service.

5.2.3 Acceptance of a referral

Once CPCS determines a child/young person and their family/carers are eligible for a CPCS service (see Section 5.1.2), they meet the prioritisation criteria if necessary (see Section 5.2.1 — this applies only if the CPCS have limited capacity), and the CPCS have a vacancy, the referral will be accepted by the CPCS and then proceed to case allocation.

5.2.4 Case allocation

CPCS will allocate the child/young person and family/carers to a CPCS counsellor within a week of acceptance of the referral. If there is an unanticipated delay in allocation (e.g. counsellor is on sick leave), the CPCS coordinator will ensure interim plans are in place. Some situations may require allocation of more than one counsellor, such as with large family groups or complex family structures (if capacity and team structure allows).

In determining case allocation, the CPCS manager or clinical lead or delegate will take into account prioritisation factors, the volume and nature of counsellors' caseloads, the changing circumstances of the child/young person and their situation, worker safety, and the skills and supports required. These factors do not change whether the case is accepted, but may influence to whom the case is allocated, whether it requires one or more counsellors, and how the counsellor will be supported.

CPCS will discuss the next steps to meet with the child/young person and family/carers with the referrer and other services involved. Professional judgement, including consideration of the circumstances of each case will determine how the initial meetings will occur. For example, an initial phone call to a family from a CPCS counsellor may be less threatening than the first contact being through a face-to-face meeting.

Cases cannot be allocated to a student on placement with CPCS as a primary worker; however, students can be allocated as secondary workers.

CPCS has clinical responsibility for the child/young person and their family/carers as clients of the service once the referral has been accepted during the intake process and beyond to all work with the child/young person and family/carers. It is the CPCS team that holds this responsibility, not an individual counsellor. This means that if a counsellor is not available for any reason once the referral has been accepted and the case allocated, the CPCS manager or clinical lead, or someone they delegate, will provide coverage. Similarly, it may be appropriate for the CPCS manager or clinical lead to transfer responsibility from one counsellor to another at any point in the intervention, including if the counsellor ceases working for the CPCS.

5.2.5 Intake process

At the time of intake, a CPCS client file will be created (or re-opened if the child/young person was previously involved with CPCS). Referral information including the acceptance date will be recorded on the NSW computerised client information system (e.g. CHOC or CHIME). Written correspondence advising of referral acceptance will be sent to the referrer, including the names of all children/young people and family members/carers and the name of the allocated counsellor.

If another service is engaged with the child/young person and/or family/carers and is ceasing its role, a clinical handover discussion will occur and will be documented by the CPCS counsellor. If the other service is not ceasing its role, the CPCS counsellor will initiate discussions regarding roles, goals, and ongoing communication channels.

5.3 Access and equity

5.3.1 Overview

This section describes key aspects of the process whereby CPCS begins to work with children/young people and families/carers. These key aspects include the following:

- Promoting access so the service is experienced as inviting and non-judgemental.
- Setting up or joining collaborative practice with other services.
- Being proactive and persistent in engaging children/young people and families/carers.
- Providing outreach services.
- Ensuring informed consent wherever possible, and emphasising how this is ensured in the context of working with children/young people and families/carers involved in the statutory care and protection systems.

When addressing issues of access and engagement for children/young people and families who have experienced violence, abuse and neglect it should be recognised that this client group is often marginalised in society and may have found it difficult to access services. These families are often ‘directed’ to attend services and may not always be willing participants, often feeling judged and ‘singled out’. There are also particular

groups who experience higher levels of disadvantage and specific barriers to accessing services. These include: Aboriginal and Torres Strait Islander communities; single parent families; people who are unemployed or underemployed; people with disabilities, including mental health issues; and migrants, refugees and asylum seekers (APS Submission, 2012).

5.3.2 Access and equity

CPCS aim to provide services and programs that:

- Promote equity of service access.
- Are timely and physically easily accessible within urban, regional and rural areas.
- Demonstrate knowledge and understanding of the range of diverse needs within the community.
- Are non-discriminatory, equitable, flexible and respectful.

To help in facilitating service access, CPCS will:

General issues

- Provide services that are free of charge, private and confidential (within the limits of legal requirements such as those related to safety and child protection).
- Demonstrate sensitivity and respect in relation to issues of age, culture, ability and sexuality when working with children, young people and families.
- Identify and respond to the needs of identified target groups with particular vulnerabilities and barriers to accessing services within the Local Health District which may include: Aboriginal people; people from culturally and linguistically diverse backgrounds; people with disabilities; people with mental illness; gay, bisexual, lesbian, transgender, intersex and queer people; younger and older people; people who have visa issues; refugee groups; and people living in rural and remote areas.
- Undertake ongoing participatory planning that involves input from the community and key stakeholders and draws on CPCS client demographic data.
- Develop appropriate procedures and strategies for locally identified groups with attention to particular locally identified disadvantaged or vulnerable groups.
- Ensure the environment reflects the diversity of the community (e.g. posters, pictures, toys, and puzzles reflect the diverse 'faces' of service users).

Aboriginal people and communities

- Provide physically appropriate space for Aboriginal children, young people, families and communities to come together, such as the capacity to use an outdoor space on occasion.
- Ensure CPCS staff receive regular Aboriginal cultural competency training.
- Ensure recruitment practices are aligned with the NSW Government's *Aboriginal Employment Strategy*, and *NSW Health Recruitment and Selection of Staff to the NSW Health Service* and to provide pathways to support employees to obtain

qualifications (e.g. ECAV VET qualifications and University of Sydney Graduate Certificate), and facilitate the further development of identified positions. Career Pathways to Allied Health professions such as Social Worker and Welfare Officer training is desirable.

- Identify and build relationships with Aboriginal cultural consultants and Aboriginal communities, including engaging with elders and other leaders (see also Section 8). Access should also be promoted through liaison with Aboriginal Family Wellbeing and Violence Prevention workers and consultation with other Aboriginal workers and cultural advisers throughout all service responses as appropriate.
- For some Aboriginal families, especially those who have come from remote areas, it may be appropriate to clarify if English is their second or third language and to consult with appropriate Aboriginal workers/organisations about how to access interpreters and translations for these families. Aboriginal English is frequently used and illustrates the importance of workers having regular access to cultural consultants.

Culturally and linguistically diverse people and communities

- Ensure information about the use of professional interpreters is available to staff and that all staff receive training in the use of interpreters. Ensure that interpreter services are used for all clients who are not fluent in spoken English, in accordance with NSW Health policy (see further below). Cultural and pre-migration trauma may influence family engagement with any public agency and may interfere with a client accepting a professional health care interpreter. It is important that workers sensitively approach this issue as clients may be reluctant due to fear of stigma, mistrust of authority or other concerns due to past experiences.
- Ensure CPCS staff receive regular cultural competency training.
- Build relationships with organisations who hold expertise in working with various relevant culturally and linguistically diverse communities for the local area in which the CPCS is located.

People with a disability

- Ensuring the physical environment is accessible for people with disabilities and/or alternative more-accessible locations are organised dependent on the person's needs.
- Provide a TTY facility for clients who are deaf or hard of hearing where possible.
- Use Auslan/English interpreters for clients who are deaf or hard of hearing where possible and where requested by the client.
- Where possible, use alternative communication methods, tools and devices (e.g. communication boards) as indicated by client need and preference and/or by consulting with specialist agencies regarding these needs.

Geographic issues

- Be located close to public transport where possible.
- Be flexible in service delivery (e.g. making use of more accessible locations for CPCS work such as seeing a child/family at school, an alternative service or at home if safety of the child/young person, their parent/carer and the counsellor can be ensured — see also Section 5.3.3 on outreach below).
- Consider and plan with clients how session times and locations can minimise the impact of getting to and from the service.
- Address access and equity issues associated with Local Health District boundaries, taking account of clinical need and service capacity. For example: clients moving out of the Local Health District who wish to remain with the original service, or clients who work within the Local Health District but reside outside of it.

CPCS will ensure counsellors are familiar with relevant protocols, policies and guidelines that facilitate access to relevant vulnerable or disadvantaged groups and ensure these are freely available including, but not limited to:

- NSW Health *Disability Action Plan 2016-2019*
- *Responding to Needs of People with Disability during Hospitalisation*
- *Interpreters — Standard Procedures for Working with Health Care Interpreters*

5.3.3 Outreach

Providing services at alternative locations (outreach) or through other means (e.g. telehealth), particularly in rural areas and small communities, may improve accessibility, provide a more welcoming environment, and encourage client engagement and participation. Some families may be discouraged from accessing services due to unease about attending a government building or other formal setting. There may also be difficulties with isolation and distance (e.g. in rural and remote areas), transport, finances or child care. Purposeful use of outreach can be an important strategy for engagement and ongoing intervention. Apart from overcoming practical and emotional barriers, seeing clients in their home or another appropriate service can offer useful insight into the family or other relevant environment and the child/young person's situation that informs assessment and planning.

In providing outreach, the Local Health District will ensure:

- Outreach services are only offered if the CPCS counsellor's safety has been assessed and addressed, consistent with the *NSW Health Work Health and Safety: Better Practice Procedures* and *NSW Health Protecting People and Property: NSW Health Policy and Standards on Security Risk Management for NSW Health Agencies*.
- Clinical judgement and client's preference will influence the location of service delivery. It is also important to give attention to issues of privacy, clarity of role and client and counsellor safety when considering whether outreach is appropriate. The outreach service needs to take place in a location and environment that is accessible, appropriate and safe for the client and counsellor. The location of an

outreach service also needs to take account of what type of physical space is most suitable to facilitate the optimal type of therapeutic intervention. This may include home visits and/or appointments with clients in appropriate local agencies such as community health centres, other health facilities, Community Services Centres, out-of-home-care (OOHC) agencies and other safe locations preferred by the clients.

- The phone number and hours of operation of the outreach service are accessible to the public and widely advertised in a variety of ways.
- Outreach services involve increased costs and should be appropriately resourced.
- Services may use a range of media and technology to ensure their service is accessible to their clients in accordance with NSW Heath and Local Health District policy requirements. For example, teleconferencing or videoconferencing may be considered as an alternative to physical outreach where appropriate.
- Where possible, CPCS in rural and regional areas will develop a schedule of circuits to improve the efficiency of outreach services.
- Clients who have outreach appointments will be given the name of one CPCS counsellor to make arrangements for, or changes to, appointments.

Worker safety

Worker safety issues associated with outreach must be addressed within each CPCS taking account of specific Local Health District circumstances such as the quality of roads, the distances required, the location of the office, access to public transport and the range of other services and general infrastructure available. Worker safety is a shared responsibility between the organisation and the individual staff member. The organisation must have clearly articulated policies and ensure staff members are aware of these and must comply with these policies. In addition to the relevant NSW Health policies identified above, Local Health Districts will ensure:

- Each CPCS will have a local procedure for confirming that a counsellor who has undertaken a home visit has left the home safely.
- The CPCS manager or clinical lead is responsible for ensuring priority is given to the safety and wellbeing of counsellors in assessing whether to conduct home visits.
- If the family has experienced domestic violence, a safety and risk assessment regarding the presence of current risk factors must be undertaken, including whether the person alleged or confirmed to have used violence is in the house or continuing to have contact with family members at the home, and what safety strategies can be put in place to ensure counsellor and client safety.
- A safety assessment conducted prior to a home visit may require a counsellor to obtain additional information from Police, Family and Community Services (FACS), Child Wellbeing Units or other agencies as well as from health records.

5.3.4 Service access after hours

CPCS should undertake planning with families/carers regarding possible service access options if a crisis occurs after hours. This includes ensuring relevant services are aware of likely after-hours issues (see also Section 5.3.7 below). Where there is no access to after-hours services, CPCS will discuss with the family/carers possible strategies in a crisis situation. In each case families/carers will be provided with 24-hour telephone numbers for FACS and any relevant on-call service they may be linked with.

5.3.5 Proactive engagement

CPCS is responsible for the promotion of access and engagement of children/young people and families/carers. This involves taking a non-judgemental, proactive and creative approach to engaging children/young people and parents/carers and taking care not to assume the client is resistant, unmotivated or not caring (Berry Street, 2015). Carers also need to feel welcome and listened to as active participants throughout the process.

Proactive engagement involves being respectful, creative, persistent, assertive and adaptive. This maximises engaging the children, young people, families, carers and their networks in the therapeutic process (Berry Street, 2015). A collaborative approach to the therapeutic alliance, which includes effective engagement and relationship building with children, young people, families, carers and the broader service system, is a key factor to effective intervention (Schley, Yuen, Fletcher, & Radovini, 2012).

Given the common beliefs and emotions of parents involved in the care and protection system (parents and carers may have a complex and even conflicting array of feelings such as guilt, anger, fear, shame, confusion, hostility, blame, suspicion and depression due to negative experiences they have had in the past with the service system), CPCS will need to pay particular attention to build and demonstrate trust and trustworthiness. Building a trusting relationship creates a sense of physical, emotional and cultural safety, and requires being honest, predictable and consistent.

Strategies on how to develop the therapeutic relationship with families are outlined in Appendix 7.

5.3.6 Consent

Consent must be informed, and where possible, sought from parents and young people aged 16 years or older. Although formal consent is not required for children 15 years and younger, it is still best practice to seek consent and willingness to participate with all children and young people.

CPCS will ensure that children/young people and their parents/carers are provided with relevant information so they can give informed consent regarding information-sharing, assessment, planning and interventions. Relevant information must be provided to the child/young person and parent/carer in a way that best enables the information to be understood. This includes a clear explanation of the CPCS role and what can be expected during CPCS involvement.

For children/young people and families from Aboriginal and culturally and linguistically diverse backgrounds, consideration will be given to involving a cultural consultant or cultural organisation when establishing consent.

Seeking informed consent includes discussing potential limitations to privacy. For example, the CPCS counsellor will discuss with the family/carers that if they form a reasonable belief that the child/young person is at risk of significant harm and is unsafe, they may make a report to the Child Protection Helpline. Section 9.3 provides further information regarding making a report to the Child Protection Helpline.

If the child/young person is living in out-of-home care, the same principles of transparency, honesty and respect apply to interactions with the child/young person's carers. While the carers are not officially providing consent, building a positive working relationship through engagement and relevant and appropriate sharing of information maximises collaboration. Carers in the context of out-of-home care do not have the right to refuse a service for the child/young person, but they can refuse consent for their own participation.

Although the emphasis is on accessibility, engagement and being responsive to the needs of the family, there will be situations where the parent or child/young person remains elusive or in other ways indicates they are not willing to work with CPCS. If after a series of attempts within the first eight weeks after referral there remains insufficient participation by the family/carers, CPCS will meet with the referrer to discuss other possible approaches. A case conference may be a useful mechanism for discussion at this time. FACS may decide to issue a Parent Responsibility Contract or other court process, or other referral options may be discussed.

There should be evidence on the client's file of discussion about consent, each person's agreement to participate in the assessment and intervention, or other ways in which CPCS has received authorisation to proceed.

5.3.7 Collaboration with other services

As identified in Section 3.3 and detailed further in Appendix 7, collaborative practice and integrated service delivery is a key element of good practice in child protection and requires an appreciation of, and respect for, the roles, contributions and constraints on each service. While tailoring responses to local needs and conditions, CPCS will operate within the context of NSW interagency agreements and will, at a minimum:

- Ensure all CPCS counsellors are familiar with and adhere to relevant legislation and policy, including the *Child Wellbeing and Child Protection — NSW Interagency Guidelines*.
- Establish and maintain processes to ensure ongoing collaboration with interagency partners that gives priority to the needs of clients. CPCS may take the lead in collaborative work or support the lead of other agencies, depending on the nature of the collaboration, client need, agreements with the client, and service capacity. This may include the development of service agreements that clearly define each agency's roles and responsibilities, including who holds primary clinical responsibility. Developing and sustaining respectful and effective

collaborative relationships with Aboriginal organisations is particularly important (see also Section 8).

- Share information related to cases in accordance with legislation and policy.
- In accordance with relevant legislation and policy, obtain written consent from the client/parent/carer (as appropriate) before collaborative work commences, including consent to which agencies will be involved and the level of, and content of, information shared between agencies (see also Section 9.2).
- Initiate and/or participate in meetings such as case-planning in relation to the safety, protection and ongoing care and support of CPCS clients. This is particularly important when it concerns clients with specific needs such as those with a physical or intellectual disability or mental illness. Where possible the client will be informed and invited to participate if appropriate.
- Support CPCS managers, clinical leads and counsellors (as appropriate) to participate in appropriate local committees, interest groups, interagency networks and other initiatives relating to child protection, domestic and family violence, and other relevant issues.
- Ensure any community education and prevention activities are conducted in partnership with communities and government and non-government agencies, including observing culturally appropriate protocols for the relevant community (See also Sections 7 and 8).

6 Client services

6.1 Assessment and planning

Assessment for the purpose of this Child Protection Counselling Service (CPCS) Policy and Procedures refers to an evaluation of the safety and wellbeing of children, young people, parents and carers as well as of their social, psychological, emotional, mental, physical, and any other health needs.

Assessment, no matter how brief, allows for a relationship to start, or continue, to be built and expectations to form. Assessment in CPCS work is designed to be transformative, rather than simply collect information about a client. The manner in which the questions are asked of the client also has a therapeutic purpose and intention. Clinical assessments must not be a one-off process, but rather, an ongoing dynamic process of assessment, analysis, review and response by the counsellor/s in partnership with the child/young person, their family/carers and other professionals. Such assessments may be formal or informal and will take place during each individual intervention or interaction with the child/young person and family/carers.

6.1.1 Safety and risk assessment

At the time of accepting the referral, CPCS's role will be to assist in reducing risk and increasing safety for the child/young person, in collaboration with the referrer, the

family/carers and other agencies. Although this will usually be in relation to violence, abuse and neglect, it can also be about other potential risks, such as:

- Child/young person's behaviour placing him or herself at risk (such as absconding, substance use, self-harm, suicide).
- Child/young person exposed to risk in community (such as sexual exploitation, community violence, racial discrimination).
- Child/young person's behaviour posing a risk to the community (such as fire lighting, harmful sexual behaviour or violence to others).
- Family/carer being exposed to risks (such as domestic and family violence, community violence).
- Risk to counsellors posed by parents or child/young person or other family members (worker safety).

The dynamic nature of assessment is particularly important in the context of safety as events and circumstances may undergo rapid and frequent change which alter the nature and severity of risk and thus necessitate ongoing or continuous assessment. Attention to potential and actual risks of further harm to the child/young person is a key element of the ongoing assessment process. Assessment of risk generally includes two elements:

- What is the likelihood that a type of risk will occur?
- What is the possible degree and type of harm resulting from the risk?

Risk assessment and management is undertaken through a shared collaborative approach with other services involved. The CPCS approach to risk and safety is a continuous process of assessing, establishing, and monitoring physical and psychological safety at each point from intake to case closure. Assessing risk and establishing safety should also not only be limited to the child/young person who has been referred but also take into account siblings and other relevant children who may be at risk, parents, and extended family members.

Where Family and Community Services (FACS) is the referrer, a standardised assessment of risk and safety (SARA — Safety Assessment, Risk Assessment and Risk Reassessment tool) is likely to have been completed prior to referral. The length and nature of FACS's involvement beyond this point will be by negotiation, according to identified case plan goals, the family/carers' level of preparedness, and the outcome of the CPCS assessment.

Where risk has been assessed by FACS as high or very high and the case is being case-managed at the local Community Services Centre (CSC), these cases will not be closed until the Risk Re-Assessment shows risk has reduced to low-moderate. In instances where risk has been assessed as being high or very high and then transferred to an NGO, these families will be case-managed by Brighter Futures, Youth Hope or Intensive Family Support Programs.

Where an agency other than FACS is the referrer, any risk assessments undertaken by that agency or copies of any previous risk assessments by other agencies (e.g. a FACS SARA) that agency has on file should be requested as part of the referral process.

If during CPCS involvement safety cannot be established or re-established, this will be discussed with the referrer, and if current risk of significant harm (ROSH) is indicated, a report must be made to the Child Protection Helpline (see Section 9.3). At that time, the nature of the CPCS intervention will be guided by the circumstances and may need to change. For example, it may not be appropriate for the CPCS counsellor to provide, or continue to provide, counselling; however, they may be able to provide certain case work or advocacy activities (see Section 6.2.5) to assist in establishing or re-establishing safety. Following a report being screened as ROSH a further FACS SARA may be required to respond effectively to current safety concerns and ensure safety for certain therapeutic interventions to commence or continue.

6.1.2 Formal assessment

Focus of assessment

A CPCS assessment is inherently child/young person-centred and family/carers-focused. It seeks to ensure the child/young person's needs are met through a holistic clinical assessment that provides a bio-ecological and cultural understanding to inform a case formulation and plan for intervention.

Assessment of the child/young person's family is informed by the referral information, including reason for referral and the role family members have in the child/young person's life. Where the child/young person is living with family (or that is the plan), assessment includes exploration of the parent's ability to care for and protect the child/young person, and their capacity for change. Where the child/young person has minimal contact with family, assessment provides rich meaning for helping the child/young person understand his or her history and current and prospective relationships.

Where possible, all stages of the assessment process including case planning for an Aboriginal child/young person and family should be informed by consultation with local Aboriginal counsellors, services or consultants to ensure the assessment is culturally relevant and appropriate. Where possible, an assessment of a child/young person and family from culturally and linguistically diverse backgrounds should be informed by consultation with a specialist service. When this is not possible, such as the unavailability of such a service within the timeframe, there should be caution in any conclusions drawn and a recommendation made to seek such cultural input in the near future.

Process of assessment

The initial assessment should be completed in the first six to eight weeks of a child/young person and their family/carers being accepted into the service so that it can inform intervention planning, and provide a transparent message to the child/young person, family, carers and referrers about the sort of work they may do together. Information is gathered from various sources. These sources include:

- the referral;
- previous reports;
- direct interviews and observations;
- exploring the insights of others in the child/young person and family's life; and
- the use of standardised or semi-structured tools.

Strategies to collect the information include: through outreach and office visits with the child and family/carer, visiting the child/young person at child care or school settings, reading files and other reports, and participating in case conferences.

The assessment process will consider the following:

- Risk and safety assessment, including the level of risk to the child/young person from others and risk to self, such as through self-harm, and consideration of the SARA (where available).
- Individual assessment of the child/young person, including current functioning and strengths and their relationships with peers, school and others.
- The needs of the child/young person, including the impact of exposure to violence, abuse and/or neglect on the child/young person's wellbeing and functioning; i.e. biological (physical, neurobiological), psychological (emotional, developmental, cognitive, educational) and social (relational, environmental and cultural).
- Developmental history of the child/young person, with a focus on the experience of adverse events at different times in their development.
- Summary of the history of placements (where relevant).
- Presenting problems and history of presenting problems (onset, duration, course, severity) with an emphasis on the possible mechanisms by which the child/young person has experienced harm.
- Family/carer assessment (may include parenting capacity, family functioning, siblings and other significant relationships).
- Child/young person and family/carers' wishes for their future safety.
- Relevant cultural and language issues (personal, family, community) and the child/young person and family/carers' relational, community and cultural context.
- Family structure, including a genogram.
- Parents/carers' history, including their own attachment experiences and trauma.
- Capacity of parents and/or carers to protect the child/young person from significant harm as well as respond to their needs.
- Cognitive and educational needs.
- Previous assessments and interventions.
- Psychiatric history (child/young person and family history).

- Medical history, including current medications.
- Potential supports and barriers to engagement and change.

Clinical outcome measures

CPCS will use a core set of mandatory standardised outcome measures to inform the assessment process, to be followed up at case reviews and closure. The Local Health District is responsible for ensuring that CPCS counsellors can administer these tests appropriately, including through access to relevant resources such as the tests themselves and necessary training.

Additional tools based on clinical judgement can be used by seeking endorsement by Violence, Abuse and Neglect (VAN) Senior Executives in conjunction with the Ministry of Health. This helps to ground the assessment and provide an evidence informed baseline to assist tracking change over time. Desired changes will depend on the particular referral goals, but are usually in relation to increasing child/young person safety, wellbeing and stability.

There is further discussion of the use of clinical outcomes measures, specialist assessment, and considering parenting capacity during assessment in Appendix 10.

Case formulation arising from assessment

Assessment guides the case formulation. The essential purpose of a case formulation is to move from understanding the child/young person's current presentation, through analysis, to an appropriate intervention plan.

The formulation is a descriptive, explanatory narrative that utilises the 5 P approach:

- Problems (current presenting problems).
- Predisposing factors (which may have led to the child/young person's situation, including presenting problems).
- Precipitating factors (which may precipitate the current issues).
- Perpetuating factors (which may contribute to perpetuating the problems for the child/young person and family).
- Protective factors (internal and external strengths and resources available to the child/young person and family/carers).

For each of the 5 Ps, critical dimensions such as biological, psychological, familial, socio-cultural (including input from cultural consultants), and spiritual need to be considered.

The formulation needs to be written in plain English that is understandable, concise and free from jargon (Havighurst & Downey, 2009) so the child/young person and family/carers understand what is expected of them, and what they can expect of the CPCS.

Assessment report

Following the completion of the assessment process, a report is written that documents the process and outcomes of the assessment and provides the basis for an intervention plan. The following approach should be followed to help ensure the quality of the assessment report:

- Where possible, it is valuable to actively involve the child/young person and family/carer in deciding the content of the report.
- The report should always be written with the readership in mind:
    - The key readership for CPCS assessment reports is the child/young person's case manager, the referrer, the child/young person (depending on age and circumstance), parents, carers and other professionals.
    - Although copies of the report will usually be given to and discussed with the child/young person and parent/carer, in some circumstances that may not be suitable. In that situation, this should be discussed with the CPCS manager or clinical lead and noted on the case file.
    - Whether the child/young person is given the report at the time, it should always be written knowing that they may read it later in life. For example, they may access the report when they are older and trying to make sense of their history, the importance of which is evident in the *Forgotten Australians* report.
    - The assessment report may be subpoenaed for courts and should be written with this in mind. For example, facts and opinions should be clearly delineated.
    - The client's file should state who has received a copy of the report.
- The report should be placed in each family member's client record. Considerations should be given to the type of information included in the report, and whether the information is being provided to the person/s causing harm.
- Language should be objective, straightforward and clear. It should be as accessible as possible, taking into account different levels of literacy and any language differences.
- The assessment is a narrative that tells the child/young person's story, including the family context. It should lead the reader logically to the conclusion (case formulation), intervention plan and recommendations. It needs to concisely explain assessment, formulation and intervention planning to help readability and usability.
- Children/young people's development is flexible and dynamic. Assessments should clearly state that conclusions relate to the current circumstances and time and should not be relied upon in the future without reappraisal. However, it should be accurate for that time and place
- Careful consideration should be given to the inclusion of sensitive information in the report, particularly as it relates to third parties such as family and carers. It should only be included if relevant to the assessment and written with consideration of who will read the report both now and in the future. Any potential

confidential information, such as a parent's address if it is not known to the other parent, should not be included.

- The assessment report should be completed within a reasonable time period after the case acceptance. A timeframe for the assessment should be discussed at the time of referral. A general principle for timeliness is between six to eight weeks.
- If it is not possible to collect all information in the initial timeframe, the intent of the assessment report is to outline sufficient understanding of the child/young person and family/carers to form the basis for a formulation and intervention plan.
- When information is not known, it should be stated rather than assumptions made without clarification. For example, a recommendation may include the need to gather additional information about a particular area.
- Where possible, the report should be discussed with the parents/carers and child/young person prior to finalisation in order to include their reflections. This can be part of the engagement process and can enhance their sense of inclusion and participation.
- The CPCS counsellor should discuss the final draft of the report and recommended interventions with the CPCS manager or clinical lead.
- Every assessment report must be signed and dated by the author and countersigned and dated by the CPCS manager or clinical lead.

6.1.3 Intervention planning

Interventions need to be planned and delivered in partnership with children, young people, families and carers, with reference to the referral, assessment and evidence-based practice to achieve the best possible outcomes. Setting goals for change and planning interventions are key elements of best practice.

Intervention planning is focused on two main components; identifying goals for change (the intervention goals) and the plan for achieving these goals (the Intervention Plan).

Intervention goals

The goals developed should: a) incorporate the primary goal for referral (e.g. preservation, restoration or placement sustainability); b) be informed by the assessment process; and c) incorporate what the family/carers want and/or need. Best practice suggests that the more actively a child/young person, family and/or carer participates in the process of setting the goals, the more likely they are to achieve those goals (Miller, Duncan, Brown, Sorrell, & Chalk, 2006). The CPCS counsellor should therefore consider how best to engage the child/young person, family and/or carers in this process.

The goals should be person-centred, child/young person-focused and family/carers-centred (see also Appendix 7). They need to be achievable and give the child/young person and family/carers ownership of the plan. SMART (Doran, 1981) is a mnemonic to guide setting goals and stands for:

Specific
Measurable

Attainable
Relevant and
Time-specific

The Intervention Plan

The Intervention Plan should detail the approach to intervention. Like the intervention goals (see above), it should be informed by the referral and assessment process as well as the identified needs/wants of the family/carers. The CPCS theory of change (See Appendix 8) and the application of specific evidence-based interventions will also influence the plan. Further discussion regarding evidence-based interventions is in the next section (Section 6.2).

If there is disagreement by the child/young person, family, carers and/or the referrer about CPCS's suggested approach, this should be discussed in a transparent and timely manner with them as appropriate. The child/young person and their family/carers should not be coerced to participate. However, discussion with the child/young person and their family/carers about the options and benefits or disadvantages of work with CPCS is essential. It is the responsibility of CPCS to proactively engage the child/young person and family/carers and to respond to indications of resistance. This apparent contradiction highlights the importance of a collaborative approach with the child/young person and family/carers. For example, if the child/young person or parent/carer refuses to see the CPCS counsellor in a session, discussions should occur regarding where else they may meet, who else may be present and possible consequences of this refusal.

It is ultimately CPCS's decision about how they will work, as long as it is consistent with the child/young person and family/carers' wishes, and the FACS case plan and/or referrer's case plan (as relevant). For example, if a referrer is of the view that CPCS should explore the child/young person's experience of trauma overtly, and the CPCS counsellor is concerned that the time is not right, or that other interventions that include work with the parent/carer needs to occur first, this should be discussed in supervision. It is ultimately a clinical decision made by the CPCS counsellor in conjunction with their manager or clinical lead. Feedback should be provided about this decision to the child/young person, family, carer and/or referrer as appropriate.

The Intervention Plan should be reviewed regularly and in collaboration with the child/young person, family/carers, the referrer or other involved agencies as appropriate. Any major change in the child/young person's circumstances, changes in the FACS case plan, changes in a child/young person or parent's wellbeing, a lack of change, and/or there is a positive or negative change in safety and risk assessment will also require review.

At a minimum, progress should be monitored throughout the intervention via the supervisory relationship between the CPCS counsellor and their manager or clinical lead, interagency case meetings, and regular case reviews.

6.2 Interventions with clients

6.2.1 Interventions in the CPCS context

The following section focuses on interventions with children/young people and their families/carers that focus on physical and emotional abuse, neglect, and exposure to domestic and family violence. The interventions identified may also be relevant to other forms of violence, abuse and neglect involving children. However, as noted in Section 1.3, the clinical practice of CPCS counsellors should also be guided by relevant NSW Health policy including, but not limited to: *Sexual Assault and Children under 10 with Problematic or Harmful Sexual Behaviours Policy and Procedures* (in development) and *Domestic Violence — Identifying and Responding*.

Child Protection Counselling Services (CPCS) have two key roles:

- to help children and young people recover from the impact of violence, abuse and neglect; and
- to help families/carers to ensure the child/young person is in a safe and nurturing environment free from violence and to repair relationships after experiencing trauma.

As such, CPCS is often working towards change for both the child/young person and family/carers.

As is evident in the Framework for Practice and the importance of the socio-ecological model for CPCS (see Section 3 and Appendices 6 and 7), relationships are often the vehicle for healing and recovery from experiences of trauma, violence, abuse, neglect, and loss and grief. Recognising that childhood holds particular vulnerabilities and opportunities is also key. Understanding the child/young person's and family/carers' situation through a cultural lens will also help to inform engagement and intervention, and provides insights into how to support their recovery.

Although interventions with individuals and families/carers are relationship based, they are also multi-faceted and may involve various combinations of the following:

- Individual work with the child/young person.
- Individual work with the parent/carer about the child/young person.
- Family work with the child/young person, parent/carer, siblings, and/or extended family.
- Group work with other children/young people or other parents/carers.
- Systems work for individuals and families, including case work and client advocacy.

The choice of interventions with individuals and families/carers will be informed through the assessment and planning process described in Section 6.1 and may change over time as circumstances change. These interventions have been outlined below in the following categories (noting that systems support and change is provided separately in Section 7):

- establishing safety;

- providing information and support;
- therapeutic interventions; and
- casework, client advocacy and systems interventions.

Similarly to other categorisations in this Policy and Procedures, these are conceptual categories which may overlap in practice. For example, court support for a parent who is seeking an AVO as a consequence of domestic violence could be both 'providing information and support' and a 'systems intervention'; and 'establishing safety' could be a vital part of a specific 'therapeutic intervention'.

Beyond these broad categories of types of interventions, this Policy and Procedures does not stipulate particular interventions that must be used by CPCS counsellors, but rather provides guidance on what to take into account in selecting interventions and the context in which they are delivered.

The question of which interventions may be most appropriate for a child/young person and their family/carers can be difficult. Questions to help clarify this decision may include:

- What does the assessment indicate, including in terms of current safety, risk and protective factors as well as the presenting problems and targets for change?
- What does the research, practice wisdom and other available evidence suggest is the most likely intervention to be effective to lead to the desired changes in the context?
- Are there cultural considerations that add a different or additional perspective?

A developmental perspective involves additional questions to consider, especially as many trauma-informed interventions were developed with adults in mind. Developmental issues to consider include:

- The child/young person's developmental stage including chronological, cognitive, emotional, and social stage.
- Whether there are critical developmental tasks and milestones relating to the child/young person's presenting problem.
- Enabling flexibility so counsellors can prioritise the targets of interventions based on the degree to which the problems are developmentally atypical and causing problems for the child/young person (Frederico, Jackson, & Black, 2010).

Given the realities of frequent transitions and chaos experienced by many of the children, young people and families accessing CPCS, pragmatic aspects to ensuring continuity of care and intervention need to be at the forefront of intervention planning. This is another reason why clinical responsibility for the work is held by the CPCS, not an individual counsellor as discussed in Section 5.2.4. Even when a counsellor is working on her or his own in a particular site, strategies need to be in place for the child/young person and family to have a sense of who else is in the team, even if it's just phone contact.

6.2.2 Establishing safety

Violence, abuse and neglect involving children and young people can result in trauma which undermines a child/young person's safety, health and wellbeing, especially in the absence of protective and positive caregiver relationships. Restoring safety is the first step to recovery. In collaboration with other services, CPCS supports the child/young person in establishing safety and recovery from trauma while working to help the family address risk factors and build upon their strengths. When it is not possible or sufficient to ensure the child/young person's safety or wellbeing while in the care of their parents, CPCS supports the child/young person through the recovery process while in the care of others. In these circumstances CPCS works with the carers of the child/young person to establish the best environment for their health and wellbeing, while also retaining a focus and, where possible, connection with the child/young person's family and/or other significant people in their lives.

The CPCS model of assessment and intervention privileges safety and healing (e.g. through therapeutic interventions) in equal measure, and both are ever-present considerations. It is not required that safety and stability are 'established' for the CPCS counsellor to begin work with the family. Indeed, a critical intervention in and of itself is the promotion and attainment of safety and reduction of harm.

The CPCS client group has complex, multiple and chronic needs. They require an approach that responds to both protection from future harm and healing from the harms already experienced. CPCS need to work in genuinely collaborative relationships with FACS, NGOs and other services that are, or need to be, involved as well as with the child/young person and family/carer themselves to help establish safety. In this context, CPCS information and support (Section 6.2.3) and casework and client advocacy (Sections 6.2.5) roles may be particularly important in assisting to establish safety.

6.2.3 Information and support

Involvement with the child protection system, Children's Court, various other parts of the criminal justice system, health and other social service systems can be confusing and intimidating for many children, young people and their families. It is therefore important for CPCS to provide to clients interventions that include:

- ***Information***, including, for example, about: the CPCS itself; the child protection system; the nature and impact of violence, abuse and neglect involving children and young people; the legal system; their rights as victims of crime; and other health, education and social services available.
- ***Practical support***, including, for example: assessing and responding to safety needs and assisting with applications such as for victims' compensation or social housing (e.g. through writing reports or support letters). (Note, some of these activities concerning providing support may also be considered casework, client advocacy and systemic interventions as outlined in Section 6.2.5.)
- ***Court preparation and support***, including, for example: providing information and preparation for attending court; providing support in court; and providing debriefing after court matters. (See also other aspects of court work in Section 6.2.5.)

For the types of interventions involving the provision of support in particular, these may need to be negotiated with, or provided in collaboration or consultation with, Family and Community Services or another service provider with case management responsibility for the child/young person. In those circumstances, it is important to identify which agency is most appropriate to support the client with the particular identified needs and ensure each agency is clear about the scope and expectations of their respective roles to ensure consistency and prevent duplication.

6.2.4 Therapeutic interventions

Evidence-informed practice

Evidence-informed practice (or evidence-based practice, as these are often interchangeable terms) is a more inclusive concept than evidence-based treatment. It is a client and clinician-directed process, rather than solely an application of research to a presenting problem. Evidence-informed practice relies on the clinician's ability to understand the child/young person and family's situation and safety, as well as the available interventions, and integrate all the elements. Evidence-informed practice enables practice to be more person-centred so that interventions can be tailored to the individual, including their needs, strengths and wishes (Brandt, Diel, Feder, & Lillas, 2012).

There is a suite of therapeutic interventions that is considered best for evidence-based practice for children/young people who have experienced violence, abuse and neglect and their families, and these are described further in Appendix 7. The table (Table 2) below provides a list of examples of types of therapeutic interventions targeting either the child/young person or the parent/carer. Some of the parent/carer interventions are more likely to be focused on the parent than the carer, such as trauma-focused therapy; however, there may be times when they are also applicable to carers such as kinship carers. The table also provides examples of systems interventions which are addressed in more detail in Section 7 below.

Table 2: Examples of child/young person and parent/carer-focused interventions

Target for change	Changes for the child/young person	Changes for the parents/ carers
Individual interventions	Attachment-based therapies Trauma-focused therapies Developmental interventions Psycho-education Cultural work	Trauma-focused therapies Cultural work Psycho-education Skills training
Family interventions	Building structures and routines Attachment-based therapies Family therapy Cultural work	Attachment-based therapies Family therapy Parenting skills education Psycho-education Cultural work Support

Table 2: Examples of child/young person and parent/carer-focused interventions		
Target for change	Changes for the child/young person	Changes for the parents/ carers
	Psycho-education Parent support	
Group interventions	Peer group activities Group therapy Group psycho-education Cultural group work Play groups	Parent group therapy Social group activities Cultural group work Play groups
System interventions	Case conferences Advocacy Referrals Training Consultation Court work	Case conferences Advocacy Referrals Training Consultation Court work

6.2.5 Casework, client advocacy and systems interventions

System work involves case work and client advocacy as well as education and consultation so that the child/young person and family/carers experience the service system as a therapeutic alliance. (See also Section 5.1.4 on pre-referral consultation and Section 7 on system support and change.) Effective collaboration is a shared responsibility across services, and essential to all aspects of practice (see also Section 5.3.7).

Casework, client advocacy, and systems interventions are therefore critical components of the CPCS response to violence, abuse and neglect involving children and young people. This is particularly because, to be effective in responding to this client group, addressing the clients' 'state of affairs' can be equally as important as addressing their 'states of mind' (Scott, n.d.).

Case management coordinates individual client care with the aim of improving service access and provision. It aims to strengthen outcomes for families, children and young people through integrated and co-ordinated service delivery between services and interagency partners to their clients. Case management is particularly important for clients with complex and multiple service needs such as those accessing Child Protection Counselling Services (CPCS).

Family and Community Services (FACS) usually retains case-management responsibility where there is risk of significant harm and there is an open and active child protection case with FACS. In some cases, however, there may be a designated NGO with contracted case management or family preservation services (lead agency) involved or a child/young person may have been accepted by the Helpline as at risk of significant harm but the case has not been allocated or progressed for a range of reasons.

CPCS do not usually provide case management for children, young people and families accessing their services; however, they may need to provide a range of casework[5], client advocacy and systems interventions activities that may include (but are not limited to):

- Attending and/or providing input into case meetings and other case coordination processes to inform activities to help enhance the safety, welfare and wellbeing of a child or young person.
- Attending and/or providing input into meetings or activities, such as Safety Action Meetings (see Appendix 2), that concern violence, abuse and neglect or other issues related to the parent/s that may impact on the safety, welfare or wellbeing of the child/young person.
- To support engagement and to establish and/or maintain safety, actively assist the child/young person or parent/carer to negotiate the service system in order that they meet the agreed goals. For example, support a parent to attend Housing appointments, where inadequate housing or the need for alternative housing as a result of domestic violence is impacting upon the parent's capacity to reduce risks for the child/young person and to increase their safety.
- Beyond providing information and support (see Section 6.2.3) or referral to other services (see Section 5.1.11), actively advocating with another service or system (e.g. another Health service or FACS) for them to intervene or provide services to ensure the needs, rights or entitlements of a particular client/s is met. This is especially important in the context of establishing and/or maintaining safety for the child/young person. It may include activities that are formal (e.g. a letter) or informal (e.g. a phone call). It could also include 'warm' referrals such as attending the first appointment with a mental health worker who will assist the parent/carer to address ongoing mental health issues that are impacting on their capacity to parent.
- Court work including assisting to prepare reports such as Victim Impact Statements or providing expert reports, evidence or other information as required to support prosecutions or other court matters in the interests of the child/young person's safety, welfare and wellbeing (See also Section 6.2.5).
- Assisting clients to better negotiate multiple services and service systems by, for example, actively collaborating and providing a seamless response to the client in partnership with other relevant services (see also Section 5.3.7). This might include, for example, coordinating joint assessments between one or more services, or sharing information from standardised assessment tools (as appropriate) to minimise duplication or over-assessment.
- Providing interventions such as professional consultation, training or support based on CPCS's, or the individual counsellor's, areas of expertise with regard to a specific case. This might include, for example, providing general information to professionals in a case conference, or to a colleague also working with the family,

[5] Note: While casework involves a range of activities to support a client in having their needs met, it does not require the level of coordination and responsibility by an individual worker that case management requires (see also outline of case work and case management in the Glossary).

information about appropriate interventions for violence, abuse and neglect involving children.

6.3 Considerations for working with specific groups

This section identifies considerations for working with specific groups where there may be particular needs or challenges in providing client services that should be taken into account by CPCS. This section should be read in conjunction with information already provided on enhancing access and equity generally and for specific groups (Section 5.3.2) as well as Section 8 on working with Aboriginal children, young people, families and communities.

6.3.1 Families involved with family law matters

Under Australia's federal system of government, most of the responses to domestic and family violence, and child protection such as criminal justice, civil protection orders, domestic violence support services, men's behaviour change programs, and child protection services are the responsibility of state and territory governments. However, the Family Law System (which refers collectively to the Family Court of Australia, the Family Court of Western Australia, the Federal Circuit Court of Australia, and family law and post-separation services, including legal aid, private legal services, and family relationship services (Family Law Council, 2016, p. vii) has become a key player in dealing with separation cases involving domestic violence and child protection.

The Australian Institute of Family Studies' submission to the *Parliamentary inquiry into a better family law system to support and protect those affected by family violence* (2017) states that while most parents did not report using a family law system service (including legal and non-legal services) as their main pathway to sort out their parenting arrangements, the parents who did use a family law system service as their main pathway:

> … were more likely to report the presence of complex issues, including family violence, substance misuse, mental ill health, problematic social media use, pornography use (prior to separation) and current safety concerns for themselves and/or their child (after separation). (Carson & Qu, 2017, p. 5)

Current research highlights that it is often the most vulnerable families with the most complex needs who are turning to the family law system, but that the family law system is not well equipped to deal with the cases presenting with domestic and family violence, child abuse and neglect and other similar issues for the families. CPCS counsellors should be aware of the difficulties for families when negotiating this space, which may include:

- The disconnect between the state-based children's courts, where the focus is on determining whether or not the state should intervene to protect the child/young person, and the family law system, where the focus is on determining a private dispute between adults (usually parents) in relation to the care of a child/young person (Fehlberg, Kaspiew, Millbank, Kelly, & Behrens, 2015).

- The protection of children/young people exposed to post-separation domestic violence is limited by the continuing jurisdictional gap between the statutory child protection and the family law systems (as above), often with expert child protection reports assessing risks to children generally not available to inform the Family Courts' decision-making (Laing et al., 2018).
- Family Courts' lack of access to the evidence required to make decisions in the interest of children/young people's safety in a system designed to resolve parenting disputes where there is a reliance on the parents providing and presenting the evidence (Family Law Council, 2015).
- Families involved in family law proceedings where child protection concerns were raised, were not primarily those already known to state child protection services, but families where violence and abuse occurred or was disclosed in the context of relationship breakdown (Brown, Frederico, Hewitt, & Sheehan, 1998; Fehlberg et al., 2015; Kaspiew et al., 2015), meaning no other services are involved and evidence is hard to obtain.
- A number of family law clients (either at the family court, family dispute resolution centres, or mediation centres) who have experienced domestic and family violence, are not being assessed as domestic and family violence-affected. Some are not being asked while others are choosing not to disclose when asked (Kaspiew et al., 2015).
- Victims of domestic violence suffering secondary victimisation when required to navigate the complex and confusing systems (Department of the Prime Minister and Cabinet, 2016). For example, if a woman has separated from a violent partner, the case may be assessed as low risk as she is acting protectively to protect the child/young person. Nevertheless, she and her children may be experiencing post-separation violence, which frequently occurs in the context of child contact and negotiation of parenting arrangements (Coy, Perks, Scott, & Tweedale, 2012).
- Social justice gaps, which can affect children's safety, also arise through the resource implications of each system: while the state funds child protection services (public law) interventions, parents bear the costs of litigation in the federal (private law) system, which may be a barrier to a parent with concerns for children's safety pursuing a matter through to a judicial determination (Laing et al., 2018).

CPCS counsellors need to acknowledge the above barriers when working with families navigating the family law system. Actions to continue to support families through the process are critical and may include:

- Continuing to work with the family with a non-judgemental, empathetic and supportive approach to help mitigate any negative experiences of the family law space.
- Continuing to focus on the safety of any children and young people involved in the family and any risk associated with that safety, or lack thereof.

- Working collaboratively with other service providers, particularly those in the family law space.
- Advocating for clients, particularly for women and children who have been victims of violence within family court systems as appropriate.
- Be mindful that case notes may be subpoenaed for family law matters so ensure documentation is thorough and accurate and be clear in identifying descriptions of factual information (particularly in describing forms of coercive control and types of violence) and separate these from documented professional opinions.

6.3.2 Child/young person/family is involved with Children's Court

Intervention by the state in a child or young person's life to determine whether they can remain with their family is one of the most difficult situations a family can face. Regardless of the circumstances that led to statutory intervention, maintaining the best interest of the child/young person while balancing children/young people's safety and their connections with parents and family is highly emotive and contentious. Children, young people, parents, families and carers can find the process adversarial, distressing and anxiety-provoking, which can exacerbate previous traumatic experiences.

CPCS can play a unique role in supporting children and young people and their parents, families and/or carers through this process. The nature and extent of this support will vary according to the nature of the referral and when the court process may take place. For example, CPCS may:

- Support a parent to submit an s. 90 application to restore a child/young person into their care where their assessment and intervention has resulted in observed changes in the parent's capacity to care for their children.
- Support children/young people and carers when assessment and intervention suggest that the child/young person is best placed away from their family.
- Support a parent's process through Children's Court when they are required to demonstrate behaviour changes in order to seek the restoration of their children.

The ways in which CPCS may work with Children's Court matters include:

- Provide information to the Court to assist decision-making, both to outline the past harms that the child/young person has experienced as well as the likelihood for change of the parent(s) behaviour or circumstances that led to the intervention.
- Providing advocacy, casework and psycho-education to support a child/young person through the Court process.
- Providing therapeutic interventions that support the child/young person to maintain stability and to help manage trauma symptoms.
- Providing advocacy, casework and psycho-education and therapeutic interventions to parent(s)/carers to support them throughout the Court process.

6.3.3 Parent/carer adult survivor of violence, abuse and neglect in childhood

By the nature of child abuse and neglect, parents and carers can experience difficulties in parenting if they have experienced abuse themselves in childhood.

> The child trapped in an abusive environment is faced with the formidable task of adaption. She/he must find: a way to preserve a sense of trust in people; safety in a situation that is unsafe; control in a situation that is terrifyingly unpredictable; power in a situation of helplessness. (Herman, 1992, p. 96)

The impact of childhood violence, abuse or neglect can be significant but its severity is mediated by a range of circumstances which relate to the survivor's access to support, to healthy relationships, to community, to formal and informal services, and to other life events. Parents/carers who are survivors of childhood abuse and neglect are often vulnerable to the tactics of those who use violence in relationships, which can increase the cumulative burden upon them and is then more likely to impact upon their parenting capacity.

CPCS work should address parent/carers' experience of childhood violence, abuse and neglect as the experience of entrapment and trauma can impact on parenting and functioning. To support a parent/carer who is an adult survivor, there should be consideration of whether a referral to another service is relevant, or whether the work can be done within CPCS. CPCS will need to consider:

- The benefit to the child/young person and/or parent/family of CPCS offering a more holistic response and working with the parent/carer on these issues, which also should help address the parenting issues that are placing the child/young person at risk.
- The benefit to the parent/carer and in turn to the child/young person of a referral for the parent/carer to another service to work on issues related to those childhood experiences, with clear negotiation about which service addresses what issue/s.
- The type of service CPCS continue to offer if this referral takes place, e.g. continuing or intermittent family work, working with children or sibling groups, advocacy, and casework and how this will be managed together with the family and the other service.

'Abuse is not destiny' (Mullen & Fleming, 1998) and it is not inevitable that a parent/carer who has experienced childhood violence, abuse or neglect will always experience difficulties in parenting. Survivors of childhood violence, abuse and neglect are also very resilient and, for many, it is only when particular life events occur (such as pregnancy and birth, experiencing domestic violence in a new relationship, or loss and grief) that parenting and/or functioning may be impaired to an extent that it places the child/young person at risk. It is the role of CPCS to explore acts of resistance and resilience as well as the strengths of an adult survivor to support the child/young person while simultaneously working with the parent/carer to make changes needed for improved parenting capacity and to appropriately care for the child/young person.

6.3.4 Parent/carer has mental health concerns/illness

Many parents/carers who have contact with CPCS will have historical and/or current mental health concerns/illness. Frequently, these mental health concerns are precursors to, or the consequence of, previous experiences of trauma and adversity, such as physical or sexual assault or childhood experiences of abuse and neglect (Bromfield, Lamont, Parker, & Horsfall, 2010). Experiencing mental illness often coincides with other complex issues, and parenting capacity may be compromised as a result. Consequently, children whose parents experience mental ill health are particularly vulnerable to cumulative harm where the unremitting daily impact of multiple adverse circumstance and events has a profound and exponential impact on them (Bromfield & Miller, 2007).

An integral part of CPCS service delivery is to work with parents/carers to support families to make and sustain changes to better meet the needs of their children. Maintaining a family-focused, child/young person-centred approach (see also Appendix 7), CPCS counsellors need to identify and address the issues that are impacting on the parent/carer's capacity to parent and work to ameliorate the impact of these issues on the child/young person. It is particularly important to assess and understand both risk and protective variables (Huntsman, 2008).

In circumstances where the issues are acute**,** e**.**g**.** mental health diagnoses or symptoms that require hospitalisation or psychiatric care (such as major depression, psychosis, or schizophrenia), CPCS counsellors will need to refer to an appropriate service. Therapeutic interventions may be put on hold at this time, but CPCS work should continue, moving to advocacy, casework, and/or assessment roles, as appropriate, which could include warm referrals and support of the child/young person and other family members, until symptoms subside and the parent/carer is ready and willing to re-engage.

Where parents struggle with mental health issues such as depression, anxiety, self-harming behaviours and suicidal thoughts, CPCS work should continue. CPCS should work alongside mental health services to determine how to provide the best support to the parent/carer, while simultaneously attending to the support needs of the child/young person.

6.3.5 Parent or Carer has a substance use and dependence issue

If a parent/carer is identified as having a substance use and dependence issue to the extent that they impact on parenting capacity, CPCS should work with drug and alcohol services, and determine how this work is best done collaboratively to support the child/young person and their parent/carer. It is important to remember that not all substance use will place a child at risk but engagement with the parent or carer to identify misuse can provide an opportunity for the parent/carer to address the use and seek treatment. If the parent/carers' substance misuse escalates and specific treatment is required, CPCS may temporarily cease therapeutic intervention but continue to perform the other aspects of their role as outlined above. In such cases, a report to the Child Wellbeing Unit or Child Protection Helpline may be appropriate if this escalation increases the risk to the child/young person and the CPCS counsellor believes the child/young person is at risk of significant harm (see also Section 9.3).

6.3.6 Child/young person has experienced sexual assault and/or has problematic or harmful sexual behaviours

As already noted, as a NSW Health, trauma-informed, violence, abuse and neglect service, CPCS provide responses for both their primary clients and responses to other violence, abuse and neglect issues when the primary referral is as a result of physical violence, and abuse, neglect, or exposure to domestic and family violence. CPCS therefore provide services for children and young people who have experienced sexual assault and children under the age of 10 with problematic or harmful sexual behaviours (see Section 5.1.7) where that child/young person also meets the service criteria for CPCS (see Section 5.1.2). Seeing and understanding sexually harmful behaviour is fundamental to good practice when it is identified in children under 10 years. This is because we know that most children with sexually harmful behaviour have been exposed to repeated childhood trauma. These childhood traumas can include: parental substance use and dependence, poor supervision, abuse, neglect, and emotional or physical violence (NSW Family and Community Services, 2016). In certain circumstances, the CPCS may also provide services to children and young people aged between 10-17 years old with harmful sexual behaviours following consultation with, and approval from, New Street and appropriate Local Health District management approval where that child/young person meets the service criteria for both New Street and CPCS (see Section 5.1.8).

A CPCS counsellor may become aware of issues regarding sexual assault or problematic or harmful sexual behaviours at any stage, including during the referral process or during the course of interventions. When the CPCS counsellor becomes aware of this information, particularly where it is not provided on referral, they may need to report to the Child Protection Helpline if the information isn't already known to Family and Community Services (see Section 9.3).

In consultation with the referrer, FACS, a non-government organisation (NGO) providing OOHC case management or family preservation services (lead agency), a Sexual Assault Service and/or a New Street Service as appropriate, CPCS may be identified as the most appropriate service to provide, or continue providing, a service for the child/young person or family/carers concerning the sexual assault or problematic or harmful sexual behaviours. In these circumstances, the clinical practice of CPCS staff in responding to these secondary presenting issues should be guided by relevant parts of NSW Health policy including, but not limited to: *Sexual Assault and Children under 10 with Problematic or Harmful Sexual Behaviours Policy and Procedures* (in development) and *New Street Service Policy and Procedures*.

Depending on the nature, impact and approach to the secondary presenting issue/s and the relevant experience and expertise of the CPCS counsellor, they may need (or in the case of sexually harmful behaviour for 10-17 years olds may be required) to consult or receive clinical supervision from a Sexual Assault Service, New Street Service, or another experienced practitioner approved by the CPCS manager or clinical lead as having relevant expertise, as is appropriate for the circumstances.

In other cases, even where CPCS may have already provided interventions to the child/young person and/or family/carers, another agency (e.g. a New Street Service or Sexual Assault Service) may be mutually agreed upon as being more appropriate to provide ongoing services to the child/young person and/or family/carers instead of CPCS. In these circumstances, CPCS will provide a supported transition to the new service as appropriate and in accordance with the process for CPCS case closure (Section 6.5). In addition to an appropriate handover and transition, and depending on the nature and expertise of the new service, CPCS may by negotiation also provide professional consultation, training, supervision and/or debriefing to the new service on those issues the CPCS has expertise in, and primary responsibility for (see also Section 7.1).

There may be occasions where more than one service (e.g. both a CPCS and a Sexual Assault Service) are, or it is agreed will become, involved with the one child/young person and/or their family/carers. In this case, clear agreement of each service's roles, responsibilities and activities should be documented and regularly reviewed and the services should work in close collaboration to help ensure consistency and prevent duplication of services.

6.3.7 Children, young people and family members with a disability

CPCS will identify and resolve or reduce potential barriers to access and engagement for children, young people and adults with disability. Disability may be in the form of physical, intellectual, cognitive, sensory or psychiatric disability. Barriers could include restricted physical access to transport and buildings, or limited or no access to necessary supports that would facilitate access or participation. For example, on occasion there may be the need for an Auslan interpreter or other forms of communication support, and adjustments may be required to how information is given and received. An assessment or intervention may need to be modified considering a person's needs.

Children with disability are more likely than other children to have experienced some form of violence, abuse and neglect or exposure to other forms of trauma (Jones et al., 2012; Sullivan & Knutson, 2000). Research has also identified associations between particular types of disability and experiences of trauma. For example, people with cognitive disability, intellectual disability, communication and/or sensory impairments, high support needs, and behaviours of concern are more likely to experience all forms of violence, abuse and neglect than the general population (Barr, 2012; Sullivan & Knutson, 2000).

Local Health Districts must aim to ensure that there is equitable access to CPCS for all people in the community, including those with disability. Fear of stigma, disrespect or prior difficult experiences with service providers may impact on a person with disability and their willingness to be involved with the CPCS. Strategies for facilitating access to, and supporting ongoing engagement with, CPCS for children, young people and parents/carers with disability include:

- Interagency planning and collaboration to develop good referral links for people with disabilities.
- Seeking consultation/practice support from allied Health staff (e.g. speech pathologists, occupational therapists, psychologist, social workers) regarding communication and service accessibility.

- Demonstrating sensitivity and impartiality in relation to issues related to ability and disability when working with children, young people and families.
- Providing appropriate physical access for people with disabilities.
- Taking care not to make assumptions about how a person wishes to communicate and ensuring there is capacity to assess communication needs and have access to tools to assist in communicating with clients with intellectual and/or sensory impairments. This may include collaborating with appropriate interpreting, translating and other communication services to facilitate access for people with particular disabilities, such as hearing impairments or intellectual disability.
- Maintaining a focus on the client (and not a carer or support person, for example), particularly when there are communications difficulties to overcome.
- Affirming the client's right to make choices and decisions wherever possible within the boundaries of reporting and other legal responsibilities.
- Recognising and working with the client's abilities, communication patterns and everyday skills.
- Taking an approach to client services that is flexible and creative and which may include modifying usual counselling and other intervention strategies as appropriate to the circumstances and needs.

6.3.8 Child/young person is in out of home care

Children and young people in care face a number of difficulties 'arising from the circumstances and inadequate care that led them to being removed from their parents, as well as the aftermath and emotional effects of being separated from their parents and family' (Cashmore, 2014). The impact of early neglect and trauma can cross every area of children's lives, negatively affecting their capacity to learn basic self-regulatory skills, develop a moral sense, manage a formal educational environment and make close, trusting relationships (Furnivall, 2014).

In addition, children and young people in care also face the cumulative risk of placement breakdown, unmet physical and emotional health needs, disrupted attachment, loss of contact with siblings and extended family, and disconnection from culture, all of which can contribute to their experience of trauma.

CPCS counsellors contribute to NSW Health's work to keep children and young people safely together with their families. When they cannot safely live with their parents, NSW Health works with vulnerable children, young people, families and carers to achieve restoration wherever possible. NSW Health also provides services to children and young people in out-of-home care, and their families and carers, to address and reduce the effects of child abuse and neglect, and to meet their health and wellbeing needs.

CPCS have specialised skills to work with children, young people and their carers to support stability and connection to overcome the impacts of trauma. In the context of out-of-home care, it is important for CPCS to provide:

- Timely services to children, young people and their carers to support placement stability and reduce the risks of placement breakdown.
- Individual, dyadic and family work that includes carers that best meet the needs of the child/young person.
- A range of services, including psycho-education; advocacy; casework; and systems intervention to children, young people and their carers, when therapeutic intervention may not be possible due to placement instability.
- Coordinated and collaborative responses that ensure the child/young person is connected or re-connected with family, extended family, kin, culture and community.

6.3.9 Working with children and young people over 12 years old

CPCS work with children and young people of all ages. Working with children and young people over 12 requires an understanding of the unique emotional, psychological and cognitive changes of adolescence. Children and young people vary enormously in age, developmental stage and cultural background. Approaches adopted with a younger adolescent may be very different than work with an older adolescent (NSW Kids & Families, 2014). Engagement, collaboration, confidentiality and offering choice are the cornerstones of work with children and young people over 12. While work with their family and/or supportive adults is crucial to supporting their sense of belonging, it is equally important to recognise the child/young person's evolving independence.

Children and young people over 12 often face unique challenges:

- Many of these children and young people are victims of recent violence and abuse and/or may be at risk of future victimisation.
- Children and young people of this age sometimes victimise others.
- Many children and young people live with the traumatic effects of past child abuse and chronic neglect (Funston, 2014).

Many children and young people over 12 with serious behavioural or emotional problems have experienced complex trauma in their childhood or adolescent development. Violence against children and young people over 12 (including physical, emotional abuse and neglect, exposure to domestic violence and child sexual assault) is associated with increased risk of self-harm and suicide, homelessness, risk-taking behaviours including drug and alcohol misuse, early involvement in the criminal justice system, chronic physical and mental health problems and gambling (Ferlitti, 2002, in Funston, 2014).

CPCS counsellors should take a collaborative, respectful approach to working with children and young people over 12 that emphasises choice. This includes:

- Flexibility in where, with whom and how the child/young person is seen.
- Consultation with other services who specialise in working with children/young people of this age to explore who is best placed to work with the child/young person.

- Work with adolescents needs to include a range of advocacy, casework and support interventions, as well as other creative approaches to therapeutic interventions, and not be limited to counselling.
- Finding creative ways to address the barriers that children and young people over 12 face when accessing services. Fears about confidentiality, worker attitudes and communication styles as well as the physical environment have all been found to inhibit children and young people's access to services.

6.4 Clinical reviews

6.4.1 Focus of reviews

Given the focus of CPCS intervention is to work towards positive change it is imperative to undertake regular reviews to ascertain if such change is occurring and modify the approach to the intervention, including goals or the intervention plan as required. Regular review ensures that work with the child/young person and family/carers is monitored, and continues to address their needs while working towards the goals as agreed.

Reviews also provide an opportunity to celebrate change and achievements, and provide the child/young person, family members and/or carers with positive feedback and affirmation wherever possible.

Information gathered at the time of review is multi-faceted and includes information from interviews, direct observation and information from others. Review, like assessment, is dynamic and continues throughout the life of the case; however, setting review points provides a means of ensuring that regular reflection of the work occurs.

A review requires a fresh look at the initial assessment and previous reviews and an open mind to intervention, such as reflecting on whether the current approach is achieving the goals at the anticipated rate or whether changes to the Intervention Plan should be made. The review process is participative and should involve the child/young person, their family, carers and other service providers, including the original referrer, where possible.

Each review will take account of the following:

- A review of the goals and Intervention Plan.
- Previous CPCS reviews (where applicable).
- Clinical outcome measures if available.
- Any review meetings convened.
- Information provided outside a review meeting (e.g. an update from the referrer).

6.4.2 Key elements in undertaking reviews

- Formal reviews should occur regularly, on approximately a three-monthly (quarterly) basis, and in some situations more frequently. Reviews may occur more frequently should new issues emerge or the child/young person's situation change considerably (see Section 6.4.5).

- The CPCS manager or clinical lead is to ensure mechanisms for internal case review are established.
- Each Local Health District must develop a process for ensuring that a CPCS manager or clinical lead oversees review processes and documentation.
- The review should be undertaken in close collaboration with the referrer. This is useful to inform the family and the referrer of emerging factors that increase the risk of harm, or to advocate for the physical, psychological or cultural needs of the child/young person.
- The review process usually constitutes a review meeting and preparation of a review report.

6.4.3 Review meetings

Review meetings are held to ensure the family/carers and services are aware of any progress made towards the goals and/or to decide on new strategies if there are continuing concerns. A review meeting should involve the CPCS, the family/carer, and the child/young person, where appropriate, as follows:

- Families must be consulted about the scope and purpose of a review and may be made aware of issues to be discussed, where sharing this information does not raise or increase safety concerns.
- The relevant referrer should be involved in a review meeting.
- The scheduled timing of reviews will be established at the initial case meeting and is to be included in the Intervention Plan. The schedule for forthcoming reviews may be re-assessed on completion of each review meeting.

6.4.4 Review reports

The same principles for writing assessment reports (see Section 6.1.2) apply to review reports. There should be a structured format and documentation for undertaking clinical reviews. The review report is a structured document that contains a number of elements, including:

- Current demographics of child/young person, including placement and order status.
- Case management details.
- CPCS counsellor details.
- Progress towards achieving goals, including any barriers.
- Current formulation and goals.
- Indications of changes.
- Plans or recommendations for future work, including any changes to the current Intervention Plan.

Case formulations are not stagnant and should reflect any changes within the child/young person and family/carers' circumstances. Presentation, perpetuating and protective

factors will change to some extent, whereas the predisposing factors remain the same, although more information may be available at the time of review. The formulation should be reviewed in the context of any changes over the period since the last report and emphasis given to the current context. Where minimal changes are evident, an explanation is provided for why this is so and what amendments are proposed to the Intervention Plan to address this.

6.4.5 If a child/young person or family's situation changes

CPCS works with children, young people and families who are highly vulnerable in terms of their individual wellbeing and their context. This vulnerability can lead to the child/young person's situation worsening rapidly for a range of reasons, including further incidents of violence, abuse and/or neglect, placement breakdown, exclusion from school, rejection from family, police involvement, substance use and dependence, or other difficult experiences. These difficult situations may follow or pre-empt deterioration in the child/young person's behaviour or emotional wellbeing. A child/young person's deteriorating wellbeing may also reflect a change in their mental health condition, which may not always be attributable to an external event. Similarly, a parent's situation and wellbeing may also deteriorate for these and other reasons.

An earlier-than-planned review may be required to assist the planning process in response to the child/young person, parent, or their situation deteriorating, or to changes in circumstances which make current plans no longer feasible.

CPCS counsellors and other agencies involved should meet regularly to provide a systemic means to discuss any concerns that the child/young person's wellbeing or their situation is deteriorating (see also Sections 5.3.7 and 6.2.5 on collaborative practice and systems interventions).

Child development is not linear and a certain degree of regression can be expected as part of healthy development. This is more likely at certain ages or when children/young people are going through transitions or difficult experiences, such as loss and grief. A dynamic assessment of children/young people and their wellbeing should consider if their presentation is due to deterioration requiring a response, if it is reflective of a normal developmental process, or is expected due to a particular loss or transition (Berry Street, 2015).

If a child/young person's or parent's wellbeing is deteriorating, the first step is to recognise this has occurred, or is at risk of continuing, and to raise these concerns in supervision. Collaboration with the child/young person, family, carers and other agencies is important to better understand the situation and to develop or redesign a tailored response. The response will depend on the nature and severity of the problem, the child/young person's age, living situation, parent's or carer's response and the child/young person's legal status (Berry Street, 2015).

Potential responses to be considered by CPCS when a child/young person or family's situation is deteriorating include:

- Meet and discuss with the child/young person and/or family and/or carers and/or school or other involved agencies.
- Advocate for relevant interagency group to meet more regularly, frequently or effectively.
- Recommend or establish a professionals' case conference.
- Seek secondary consultation, e.g. from a Child and Adolescent Mental Health Service (CAMHS), paediatrician, psychiatrist or GP.
- Instigate a formal review of the CPCS Intervention Plan.
- Increase level of intensity of contact for a specified period of time.
- Develop or revise a safety plan tailored to specific emerging risks.
- Develop or revise a therapeutic plan to guide the day-to-day responses by the carer.
- Make a report to the Child Protection Helpline regarding violence, abuse and/or neglect (see Section 9.3), or raise concerns regarding a Quality of Care issue in placement with FACS or other relevant case management agency.
- Advocate for an inpatient admission to a mental health service.
- Advocate within the service system regarding particular concerns, in accordance with local escalation processes and those outlined in the *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*.

6.5 Case closure

Case closure is an opportunity to provide children, young people and families with positive feedback on their achievements, and to experience what is hopefully a positive transition from the relationship with CPCS to other formal or informal supports. It is also an opportunity for clients to give feedback to assist CPCS to evaluate the effectiveness of its interventions and the overall quality of the service.

The need for timely closure is important both for current and prospective clients. To ensure that other children, young people and families/carers can also access the service, it is important to ensure that closure occurs in a timely and planned way. Developing linkages with a range of services, and considering possible markers and plans for closure, is part of the initial planning when the children, young people and families are first referred and assessed.

As with each phase of CPCS involvement, an understanding of trauma, attachment and child development should inform how the child/young person and family/carers may react to finishing involvement with CPCS, and saying goodbye to the CPCS counsellor. Even when the child/young person and family/carers are in agreement with the case closure decision, they may find the process emblematic of past experiences of rejection, abandonment and isolation. This should be carefully considered in terms of the decision and the process of case closure.

6.5.1 Principles underlying the case closure process

- ***Goal directed involvement***: At the beginning of CPCS involvement, such as when considering the referrer's goals and the child/young person and family/carer's goals for change, it is important to consider ahead to the time of case closure, such as the following:
    - What does the assessment indicate in terms of the likely pace of progress towards the goals?
    - Do the goals for change include how they can be measured? In other words, what are the possible markers of change?
    - What might indicate that case closure is appropriate?
- ***Transparency***: Decisions and the process of closure need to be transparent for all involved, including the child/young person, family, carers, referrer and other services. Reflecting on who should be informed of CPCS closure is an important component of preparation, including parents who do not live with the child/young person, when appropriate.
- ***Follow up***: Consideration at time of case closure is whether or not another therapeutic, mental health or support service would be beneficial for the child/young person or family/carers post the CPCS case closure.
- ***Continuity of care and handover***: When it is known that another service will be working with the child/young person post-CPCS involvement, CPCS will make all efforts to ensure continuity of care by effectively communicating with the new service (in accordance with the child/young person's and/or family/carers' wishes). This aims to maximise the transfer of information and assist in future planning and therapeutic intervention. It includes providing that service with a copy of the CPCS closure report if appropriate.
- ***Review of progress***: A case conference may be important to occur at time of case closure as it enables other professionals to hear the clinical insights from CPCS and to consider if there are other decisions that need to be made in preparation for, or following, CPCS ceasing involvement.

6.5.2 Participation

Involvement of children/young people and their parents and/or carers in planning case closure is an important part of the process. As many children/young people and their parents have faced significant losses in their lives, their preparation and involvement in the closure process is important to give them a sense of control and inclusion as part of their healing process.

Closure sessions with children/young people and their families/carers should provide them with positive feedback on their achievements, and should include seeking their feedback of the services provided.

A formal review, celebration or a graduation-style session may be considered on case closure to provide a sense of occasion for highlighting a child/young person's and/or family's achievements during intervention. The format will vary depending upon the

length of intervention, type of therapeutic relationship that has been established and the child/young person's and family's wishes.

6.5.3 Transition: planning and preparation for closure

As with each other aspect of the CPCS pathway, transition towards case closure should be based on the child/young person's and family/carers' needs and informed by what is most likely to support the child/young person and family/carer to the next phase. Continuity of care is a key principle here. Planning and preparation for case closure should include:

- CPCS case closure should occur once the goals of the intervention, as articulated in the referral and intervention planning process, have been adequately addressed. Not all the issues in the child/young person's and family/carers' lives will be resolved by CPCS involvement.
- Around the time of a planned closure, the CPCS counsellor should review the initial goals established between the CPCS, any other relevant services (including the relevant Aboriginal organisation and/or cultural consultant where the child/young person is Aboriginal), and the child/young person and family/carers. This review of goals is undertaken in order to ensure that issues have been adequately addressed.
- Discussion regarding closure must be subject to a meeting between CPCS, the child/young person and their family and/or carers, and other relevant agencies involved, where possible. This meeting will usually discuss issues such as the child/young person's and family and/or carers' progress, their current situation, reason for closure and future plans.
- There may be an opportunity for joint work between CPCS and the new service for an overlapping time period. This could assist the child/young person and family through the transition process and support effective information-sharing and engagement.
- The referrer must be informed in writing of the closure and provided with a closure report or letter, as appropriate. A closure report or letter provides a means to inform the referrer and other services of issues that have been addressed and those that may require further action. It is particularly relevant where a child/young person or family prematurely terminates contact with the service.

6.5.4 Case closure reports and letters

Case closure reports should encapsulate the child/young person's and family's involvement with CPCS and the directions forward. The level of detail will be informed by whether other reports have preceded this report, or if it is stand alone. If there is little information available, such as if the CPCS role finished prematurely, then a closure letter to the family/carers and key services may suffice.

Where possible, it is valuable to actively involve the child/young person and family/carers in deciding the content of the report. A case closure report should at a minimum:

- outline CPCS's overall involvement.

- summarise key messages from the CPCS assessment.
- outline what has been learnt from assessments undertaken by others.
- provide details of the intervention including the issues covered, frequency of sessions, and length of involvement.
- describe what, if any, changes were observed over time.
- discuss any remaining concerns and/or recommendations for possible further action.

If there are ongoing risks for the child/young person at time of closure these should be articulated in the case closure report and through the interagency case conferences/meetings, including specific recommendations about the risk management response provided and/or required.

The child/young person, parents and/or carers should also be provided with a copy of the case closure report, except where it is considered that this may place the child/young person or family at further risk. In these instances, separate to a case closure report, a closure letter may be given to the child/young person, family/carers and others involved. This should include the date and process of CPCS closure, and who to contact if they have further questions. It will also include any information regarding other services that are involved or recommended. When clinically indicated, a closure letter could include more overt therapeutic intent, such as a 'therapeutic letter' designed to give the child/young person or family key messages for continued reflection. As with other clinical decisions, this should be discussed in supervision (Berry Street, 2015).

6.5.5 Referral to other services and follow up

When required, referral to another service needs to be an active process facilitated by the CPCS. Such referrals should observe the approach identified in Section 5.1.11. As part of the closure process, many children/young people and families will benefit from direct handover meetings with the new service, their CPCS counsellor and the original referrer where appropriate. The CPCS counsellor will inform the child/young person and family/carers of the purpose of any such referral and the nature and content of information exchanged.

All contact with a client after closure is to be documented and must be strictly limited to that required to provide the client with information to assist them to access appropriate services or supports to meet their ongoing needs.

6.5.6 Unplanned case closure

There are situations that can lead to a case being closed with little time for planning or preparation. A parent or child/young person may no longer wish to be involved with the service, may move interstate, or a crisis or adverse event may significantly change the case plan and CPCS involvement is no longer appropriate.

Sometimes a child/young person or parent will not wish to continue with the service and decide to either actively finish by informing the CPCS counsellor, or may passively

terminate by missing sessions. This will be discussed with the CPCS manager or clinical lead before a decision is made to close the case to ensure there is adequate exploration of other strategies to re-engage.

Where a child/young person or other family member wishes to cease involvement, the CPCS counsellor must demonstrate reasonable and varied attempts to re-engage them wherever possible. This includes phone calls, home visits (if appropriate and safety issues are addressed), or sending a letter outlining what has been achieved, and the therapeutic benefits to be gained by continuing their work with CPCS. These contacts are documented on the client file.

In every unplanned closure, an assessment of the risk to the child/young person needs to be completed and discussed with the CPCS manager or clinical lead. This should also be discussed with the referrer, and/or other relevant services (e.g. mental health) for advice and potential action, or other forms of follow up.

If the child/young person and family have moved, or are about to move, interstate, consideration should be given as to whether there is an appropriate therapeutic service available in that area. This may require discussions between FACS and the relevant statutory child protection service in the other state or territory.

6.5.7 Re-referral to CPCS

For CPCS to re-engage with a child/young person and family/carers following case closure, a new referral is required. A consultation should occur first to see if a new referral is warranted, or if CPCS can offer other more appropriate referral options or suggestions at that time. The new referral will be prioritised along with other referrals to CPCS (see Section 5.2.1), and is not given higher priority than other referrals. There will be consideration about how a re-referral to CPCS would likely benefit the child/young person and family.

Once accepted, the previous CPCS file will be re-opened and information made available to the new CPCS counsellor as appropriate.

7 Systems support and change

Prevention, of violence occurring or reoccurring and of further harm, is central to the public health approach that underpins NSW Health's responses to violence, abuse and neglect (Section 1.2). The nature and scale of violence, abuse and neglect involving children and the, at times, inadequate responses of our health, justice and social service systems and our communities more broadly necessitate interventions beyond those with individual clients. The expertise of CPCS in the content area and depth of their work with various children, young people, families and carers uniquely positions them to observe patterns and make a significant contribution to systems support and change. This includes activities to support or change responses to violence, abuse and neglect with professionals, in service systems and with communities. In helping to make institutions and communities safer for children and young people and to provide better responses when they are harmed, systems support and change enables CPCS to make a much

broader positive contribution. It also helps minimise staff burnout by providing balance through diversifying their work and interventions.

7.1 Professional consultation and training

7.1.1 Consultation

As identified in Section 5.1.4, CPCS may provide consultation to help facilitate access to the service and support interagency collaborations. Importantly, however, CPCS also provides consultation within the service system with the aim of strengthening the capacity of other professionals to work effectively with children, young people and their families who have experienced trauma and disrupted attachment. Such consultation is a key element of services provided by CPCS and contributes to the wellbeing of children and young people in general, beyond the CPCS client group.

Although case responsibility remains with the worker seeking consultation, CPCS is responsible for the quality of the consultation, within the parameters of the information provided. Consultation commonly involves making recommendations and suggestions for consideration, and it is up to the consultee to decide whether or not to act on that advice (Berry Street, 2015). Consultation and training can include activities that are both formal (e.g. providing clinical supervision or a formal training session) and informal (e.g. advice over the phone or ad hoc debriefing).

In addition to facilitating the referral and intake process (see Section 5.1.4), functions of consultations provided by CPCS include:

- to assist case analysis and problem solving with other workers.
- to build capacity in other services through sharing knowledge and encouraging reflection.
- to support collaboration, such as where one service has the relationship or mandate with the child/young person or family/carers while CPCS have expertise and knowledge that can contribute.

Consultations can provide specialised knowledge regarding a range of issues CPCS have expertise in, such as: violence, abuse and neglect involving children; child development; attachment; and trauma; as well as other areas of knowledge such as appropriate interventions to help achieve better outcomes for children, young people and their families.

As a general principle, if consulted about an area of practice that is outside a CPCS counsellor's area of expertise, it is their responsibility to seek other options. CPCS counsellors are not required to be subject matter experts in all areas of child protection; however, they are responsible for identifying and referring on to people with relevant expertise when needed.

While the consultee is responsible for the recording of advice received on their organisation's client file, the CPCS counsellor will also keep a record of the consultation. This record will be in a format which enables CPCS to record the details of the consultee,

the nature of the consultation and the outcome, including the time taken to provide the consultation.

It is the consultee's decision as to whether or not to accept the advice or information from CPCS. If CPCS are concerned about the child/young person's safety they should discuss these concerns with the worker seeking consultation and document this in their notes. If CPCS remain concerned that a child/young person is at risk of significant harm, they could discuss with a child's FACS or OOHC caseworker, if available, or can make a report to the Child Protection Helpline in accordance with NSW Health policy (see Section 9.3) if they have sufficient information to do so. It is usually preferable that the person who knows the child/young person makes a suspected ROSH report has these discussions with the Child Protection Helpline; however, if they have indicated they are not going to report and the CPCS counsellor believes the child/young person is at risk of significant harm, they should act on this.

When providing consultation, it is important to clarify expectations and not make assumptions about the other worker's context. It is particularly important if the child/young person or consultee is from a different cultural background to ensure that any consultation provided is culturally respectful and informed.

Overlapping with consultation concerning professionals' engagement with children, young people and families, CPCS counsellors may also be in a unique position to provide support, debriefing, and/or advice including referral for other professionals who are triggered by the violence, abuse and neglect issues they are consulting with CPCS on. It is important to note here that in addition to the high prevalence of violence, abuse and neglect in the general population (see Section 2 and Appendix 1), there are many professionals and, in particular, health workers with their own histories of violence, abuse and neglect (McLindon, Humphreys, & Hegarty, 2018). CPCS counsellors need to be mindful of this common experience of violence, abuse and neglect in providing consultation services to professionals and seek to identify and provide support and referral in situations where professionals consulting them may be in need.

7.1.2 Training

To support Local Health Districts' responses to violence, abuse and neglect, CPCS may be involved in providing training to other parts of the Health system or agencies outside of the Health system; for example, mandatory child protection induction training, or training to a mental health service about the impact of trauma. Not only does this training provide opportunities for strengthening intra and interagency relationships, it also provides an opportunity to share their expertise across the system and more balance in CPCS staff members' scope of work.

7.2 Systems advocacy

While client advocacy and systems interventions seek to assist the CPCS client group to navigate and access information and services, to ensure their needs are appropriately met (Section 6.2.5), systems change seeks to influence and change these systems. This may include advocacy for legislation, policy or practice change to positively impact on the

people who have experienced violence, abuse and neglect as a whole, rather than individual CPCS clients.

Systems advocacy, which may also be known as systems change, is a 'political process by an individual or group which aims to influence policy and resource allocation within political, economic and social systems and institutions' (National Association of Services Against Sexual Violence, 2015, p. 18). It is usually informed by the experiences of the client group and particularly seeks to bring about changes where a number of clients may have had similar negative experiences of particular systems, processes or practices. The breadth and depth of CPCS work with a range of children, young people, families, and carers provides a unique opportunity to provide insights into patterns and a platform from which to provide changes that improve how our systems respond.

Examples of systems change activities that CPCS may be involved in include, but are not limited to:

- Raising the profile of issues concerning violence, abuse and neglect, including by providing expert advice on the issues in media or other public forums (in accordance with NSW Health policy and local approvals processes).
- Providing respectful and constructive feedback and working with intra- and inter-agency partners to improve their policies, procedures and practices concerning people who have experienced violence, abuse and neglect. This may include participation in, and contribution to, internal NSW Health policy development and implementation concerning violence, abuse and neglect.
- Convening, participating in, sharing information, and advocating systems change in intra and interagency groups/meetings such as: NSW Health violence, abuse and neglect managers' meetings or forums, and local violence, abuse and neglect committee meetings.
- Writing submissions or providing input into submissions for legislative or other systems change (in accordance with NSW Health policy and local approvals processes).
- Advocating for additional funding, certain evidence-based programs, service expansion or service realignment to address service gaps for people who have experienced violence, abuse and neglect.
- Involvement in local violence, abuse and neglect education/prevention programs such as Love Bites, Child Protection Week, and White Ribbon Day.

7.3 Community engagement, education and prevention

Although much child welfare practice focuses on individual children, young people and families, with limited resources or capacity devoted to influencing the structural, community-level factors that impact on children's welfare, it is becoming increasingly evident that the welfare of children, young people and families cannot be separated from the health of the community in which they live (Lohoar, Price-Robertson, & Nair, 2013). The *National Framework for Protecting Australia's Children 2009-2020*, states that Australia needs to move from seeing 'protecting children' merely as a response to abuse

and neglect, to one of promoting the safety and wellbeing of children in a broader societal context. The Royal Commission (Australian Royal Commission into Institutional Responses to Child Sexual Abuse, 2017a Vol. 6) further suggests that a focus on all Australian communities and a shift in misperceptions, attitudes and beliefs is needed to address child sexual abuse.

> Institutions interact with children across a broad range of sectors and activities, such as schools, sport and recreation clubs, support services and childcare centres. These institutions are part of the fabric of our daily lives and reflect community priorities, needs and values. Making such institutions safe for children requires making communities safe — places where every child is valued, and where their rights to safety and wellbeing are respected and upheld. (Australian Royal Commission into Institutional Responses to Child Sexual Abuse, 2017a, p. 9 Vol. 6)

Three ways that CPCS can respond by working not just with families, but with the broader community and society to reduce child abuse and neglect are through: prevention, community engagement, and community education as outlined below.

7.3.1 Prevention

Prevention of child abuse and neglect refers to strategies that seek to stop child abuse and neglect before it happens. Prevention activities seek to reduce risk factors and enhance protective factors that are associated with child abuse and neglect. The socio-ecological model (Section 1.2 and Appendix 3) is helpful in understanding the different levels where prevention work can take place: the individual, relationship, community and societal levels.

In Australia, most child maltreatment prevention activity currently takes place at the individual or relationship level; for example, parental education or home visiting programs that seek to increase knowledge of child development, improve family functioning and reduce social isolation (NAPCAN, 2017). It is important for practitioners to work with the issues that are broader than the individual family. Prevention work can also target risk factors at the community or society level. Examples of this kind of work include legislative and policy changes (e.g. the creation of Working with Children Checks or child-safe organisational policies) or media campaigns that seek to change attitudes towards children, young people or parenting.

In line with this broader prevention work is the concept of building stronger communities to support the safety of children and families. Issues that would be addressed to create stronger communities would include: community involvement; addressing social exclusion; identifying and addressing risk factors in parental wellbeing and attitudes; locally relevant and accessible programs; collaboration between services; and inclusion of both children's and parent's views (CFCA, 2016).

> Well-designed and appropriately tailored prevention initiatives could help to mobilise all community members to be agents of change. Through building knowledge and capacity, parents, volunteers, professionals and others could become better equipped to recognise and counter problematic attitudes and

behaviour that put children at risk, and know how to respond to warning signs and indicators. Community-based prevention initiatives are part of a comprehensive response to building a strong, preventive system for creating child safe organisations. These could be delivered concurrently with changes to policies and procedures, training in institutions and legislative reforms. (Australian Royal Commission into Institutional Responses to Child Sexual Abuse, 2017a, p. 10 Vol. 6)

7.3.2 Community engagement

Community engagement has a strong rationale and accumulating evidence of efficacy, and the potential to be a key strategy for improving outcomes for Australian children, young people and their families (Moore, McDonald, McHugh-Dillon, & West, 2016). Although community engagement encompasses different terms such as consultation, participation or collaboration, community engagement is 'the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the wellbeing of those people' (USDHHS p. 7, as cited in Moore et al., 2016). Community engagement can often be described as being on a continuum, with consultation placed at one end, all the way through to community empowerment at the other.

Community engagement can be seen to be a response to current systems not working effectively, it can lead to improved outcomes for families as they are able to articulate what it is they need, and it negates the damaging effects of non-participation. O'Mara-Eves, Brunton, and McDaid (2013) concluded that there is solid evidence that community engagement interventions have a positive impact on a range of health and psychosocial outcomes, across various conditions.

Core features of effective community engagement strategies that CPCS counsellors can draw from are:

- starting from the community's own needs and priorities rather than those dictated from outside;
- inviting and building local autonomy, giving leadership to people in the community and acting as a resource to them;
- building the capacity of families and the community to meet their own needs more effectively;
- having a flexible service system that can be tailored to meet local needs;
- balanced partnerships between providers and consumers based on mutual trust and respect;
- working with the community rather than doing things for them or to them;
- information-sharing so that the community can make informed decisions; and
- providing the community with choices regarding services and intervention options (Moore et al., 2016, p. 14).

Community engagement and prevention can work hand in hand to develop safer communities for children and young people, which in turn has the capacity to reduce violence and neglect.

7.3.3 Community education

The *National Framework for Protecting Australia's Children 2009-2020* describes expanding community education and awareness of child safety and wellbeing as part of an overall approach to protecting children. Education campaigns, either at a community or national level, serve to compliment both community engagement and prevention strategies. Research highlights the need for awareness programs for parents and the general community on important issues related to the safety of children. Provision of information for parents on child safety issues and risk factors such as gender, age, family characteristics, and educational programs for children in a language they understand are perceived to be an effective way to build confidence and prevent abuse (Nair, 2012).

8 Working with Aboriginal children, young people, families and communities

8.1 Working with Aboriginal children, young people, families, carers and communities

NSW Health recognises the impact of racism, colonisation, social determinants and oppression on Aboriginal children, young people and their families, caregivers and communities, and the injustices Aboriginal people and workers face in utilising or working in government and non-government mainstream services. Aboriginal people are impacted by issues such as the overrepresentation of Aboriginal children on child protection orders and in out of home care, threatened closure of remote communities, over-representation in the criminal justice and prison systems, poverty and income management policies and intergenerational trauma. These impacts are recognised in the *NSW Aboriginal Health Plan 2013-2023*, which states that the barriers faced by Aboriginal people in using mainstream services are a result of systemic racism.

Despite these abuses, Aboriginal people and communities remain resilient and deeply connected to their culture, kinship, family and history (NSW Ministry of Health, 2012; Zubrick et al., 2010). It is also evident that building connection to culture and community can help buffer children, young people and families in the face of adversity, including violence, abuse and neglect (Bamblett, Frederico, Harrison, Jackson, & Lewis, 2012).

Child Protection Counselling Services must apply the National *Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health* (Australian Health Ministers' Advisory Council. National Aboriginal and Torres Strait Islander Health Standing Committee, 2016).

Four key areas must be prioritised in order to begin to address these injustices and to support Aboriginal children, young people and their family/carers, and Aboriginal workers:

- Cultural Safety and Cultural Competence
- Community Engagement

- Aboriginal Cultural Consultation
- Supporting the Aboriginal workforce (NSW Ministry of Health, 2018).

Particularly given the over-representation of Aboriginal children in the care and protection system, CPCS need to be proactive in these endeavours. Each CPCS service is required to develop an Aboriginal Action Plan to document how it will work towards addressing these four key areas. See Appendix 12 for an Aboriginal Action Plan Template.

8.2 Cultural safety and cultural competence

The development of culturally safe and culturally competent health services is a key strategic direction of the *NSW Aboriginal Health Plan 2013-2023*. Cultural safety involves Aboriginal children and families feeling and believing that their Aboriginal identity is valued and respected, and being provided the freedom to express their identity (Victorian Aboriginal Child Care Agency [VACCA], 2008). This enables children, young people, adults and communities to experience a culturally safe atmosphere in a health service where they are not judged, misunderstood or assaulted on the basis of their cultural identity and connection.

Cultural safety is conceptualised along a continuum from cultural destructiveness to cultural proficiency (Cross, Bazron, Dennis, & Isaacs, 1989). Individuals and organisations can work towards culturally safe practice as a journey. It is not a destination that once achieved is complete. This journey involves attitudes, policies, and practices.

Cultural safety involves Aboriginal children, young people and families feeling and believing that their Aboriginal identity is valued and respected, allowing freedom to express their identity (VACCA, 2008). Culturally safe practice can only increase the accessibility and safety of mainstream health services for Aboriginal people if it acknowledges and aims to address the trauma and ongoing racism that Aboriginal people continue to experience (Herring, Spangaro, Lauw, & McNamara, 2013).

CPCS take steps towards this by ensuring that Aboriginal children, young people and their family/carers are always treated with respect and courtesy in every interaction, and that CPCS premises are welcoming and inclusive. This includes, but is by no means limited to:

- The placing of items of cultural relevance, including maps, pictures and paintings, which are sourced in consultation with local Aboriginal communities and/or the local Aboriginal Land Council, and in line with existing NSW Health policies.
- Where possible, premises will display information and posters written in culturally appropriate language and style.
- In interventions, CPCS counsellors will have knowledge of and respect for Aboriginal worldviews, and engagement will be sensitive, empowering and respectful, and support self-determination wherever possible.
- Where appropriate and safe to do so, services are provided in flexible locations preferred by the Aboriginal child/young person and/or the family/carers, including

outreach and outdoor spaces, and there is flexibility regarding meeting times and the duration of appointments.

- CPCS counsellors will meet with the child/young person and family/carers in a location where their privacy and confidentiality can best be maintained, acknowledging this can be more difficult in some rural and remote areas.
- Throughout work with an Aboriginal child/young person and their family/carer, CPCS should engage in cultural consultation (explored further in Section 8.4) to ensure cultural safety. Where possible and welcomed by the child/young person or family/carers, CPCS will co-work and/or undertake joint visits with Aboriginal workers or organisations.

Ensuring cultural safety further involves recognising the importance of the traditional and ongoing roles and knowledge of Aboriginal men and women, traditional and ongoing kinship structures, connection to family, community and country, and the importance of this to Aboriginal children, young people and their family/carers. This entails understanding the different roles and needs of adults and children, of men and women, and of boys and girls. Cultural consultation is critical to avoid misunderstandings or false assumptions (see Section 8.4).

As outlined in Herring et al. (2013), cultural competence can only be effective in increasing the accessibility and safety of mainstream health services for Aboriginal people if it addresses the trauma and ongoing racism that Aboriginal people experience. Herring et al. (2013) cite the definition of cultural competence as

> 'a system of care that acknowledges and incorporates the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cross-cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs' (Cross, Bazron, Dennis & Isaacs, 1989 in Herring et al., 2013, p. 3).

Herring et al. (2013) provide a framework for working towards trauma and racism-informed cultural competence, whereby practitioners and organisations can take the 'careful and patient' steps of *becoming informed, taking a stance* and *reaching out* to their local Aboriginal communities. This framework has been summarised in the table below.

Table 3: Working towards trauma and racism informed cultural competence

	Personal steps	**Practice steps**	**Organisational steps**
Becoming informed	Awareness of the full history of Aboriginal people, of living cultural practices, of ongoing racism and persecution.	Researching barriers to using mainstream services faced by Aboriginal people (including isolation as a result of racism and intimidation), learning about local Aboriginal communities, history,	Ensure staff are sufficiently trained in issues, such as Aboriginal history, culture, contemporary and social determinants, and trauma legacies, conduct and document scoping to establish the profile and

		practices, organisations and spokespeople.	service use by Aboriginal clients against the local population, identify existing policies for recruitment and support of Aboriginal staff, identify existing Aboriginal voices in the organisation.
Taking a stance	Recognition of the benefits of white privilege, willingness to name and confront racism against Aboriginal people.	Recognition that the service is discriminating against the Aboriginal community unless the client base reflects the Aboriginal population and the proportion of those experiencing a given problem that are Aboriginal.	Develop a draft plan for how training, policy revision and consultation will occur, prioritise access by Aboriginal people to the service in terms of time, resources and ongoing commitment.
Reaching out	Reading the work of Aboriginal writers, supporting Aboriginal cultural events, taking the initiative to engage with Aboriginal colleagues and acquaintances	Reach out to local cultural brokers, introduce themselves, spend time and identify ways to consult with and support the local community.	Contact local cultural brokers, spend time building relationships and trust, identify and offer resources (e.g. venue spaces for meetings, provision of training, provision of volunteers for celebration days), listen and ask what is needed, involve Aboriginal staff in decision-making, mentoring and supervision.

Adapted from Herring et al. (2013)

Working towards cultural competence is a responsibility of all CPCS staff. As illustrated above, trauma and racism-informed cultural competence involves a series of steps to be taken primarily by non-Aboriginal staff. CPCS managers and clinical leads are crucial in leading this process within the team and in facilitating and engaging in ongoing reflection and review on cultural competence in clinical supervision, cultural supervision, planning meetings, training and in daily practice. Training involves completion of *IN-1018 Developing culturally safe trauma informed practice in Aboriginal communities* through the NSW Health Education Centre Against Violence (ECAV). All NSW Health staff members are also required to complete the eLearning and face-to-face components of *Respecting the difference: An Aboriginal cultural training framework for NSW Health*. Each CPCS counsellor, manager and clinical lead should also engage in regular, individual and group cultural supervision, cultural consultation (see Section 8.4) and continual development and fostering of effective and long-term sustainable working relationships with Aboriginal organisations and reputable community members.

8.2.1 Cultural safety in the child protection context

An important principle adopted throughout Australia is the Aboriginal Child Placement Principle (ACPP) which acknowledges the imperative for Aboriginal children to be raised in their community. The goal of the ACPP is to enhance and preserve Aboriginal children's connection to family and community, and sense of identity and culture. Specific to issues relating to care and protection, its aims include recognition and protection of rights of Aboriginal children, family and communities, self-determination for Aboriginal people, and reduction in the over-representation of Aboriginal children in the care and protection system (Arney, Iannos, Chong, McDougall, & Parkinson, 2015). It states the preferred order of placement for an Aboriginal child beginning with the child's family, the child's community, or other Aboriginal people. It is only if these are not available that a non-Aboriginal placement should be considered (Berlyn, Bromfield, & Lamont, 2011).

Aboriginal people have many reasons, from history and current context, not to trust mainstream organisations, particularly those involved in the removal or placement of Aboriginal children. This may lead to reluctance to seek help until they are in the midst of a crisis. The crisis itself may reduce the options available (Jackson, Waters, Meehan, Hunter, & Corlett, 2013).

Key to cultural safety is understanding the perspectives of Aboriginal people, and learning in an ongoing way through consultation with Aboriginal colleagues, community members and organisations. For example, Aboriginal perspectives on healing and identity are holistic and community-based and include a belief in:

- a holistic view of the child/young person, not each need in isolation.
- the child/young person's relationship to all their family, not just parents.
- the child/young person's relationship to their community, not just family.
- the child/young person's relationship to the land and spirituality which determine law, politics and meaning.
- the reciprocity of social responsibilities between the child/young person and others in the community (Bamblett et al., 2012).

8.2.2 Cultural safety in therapeutic interventions

Each CPCS team and individual counsellor needs to listen, reflect and consider whether their practice demonstrates understanding and respect of Aboriginal history, and the importance and depth of Aboriginal culture and community today. A key step is to form a proactive and collaborative working relationship with Aboriginal workers and organisations (See also Section 8.4).

Wherever possible, CPCS will provide Aboriginal children/young people and their family/carers with a choice of whether or not their individual counsellor is an Aboriginal or non-Aboriginal person. Efforts should also be made to ensure that Aboriginal children/young people have access to an Aboriginal CPCS counsellor of their preferred gender in the context of cultural standards and expectations relating to sexuality and development. This may require collaboration with Aboriginal Family Wellbeing and Violence Prevention workers and Aboriginal workers from other organisations.

If there is no Aboriginal Social Worker, Welfare Officer (Allied Health) or Aboriginal Worker available within CPCS, the child, young person, family or carers will be asked if they wish for an Aboriginal worker or support person to participate in the sessions. This would require co-working with Aboriginal counsellors, health workers or Aboriginal organisations, including Aboriginal Medical Services. This is particularly important in the engagement process and at key decision-making points.

In considering how to undertake assessment, planning and work with Aboriginal children, young people and their families, CPCS need to ensure their approach has a foundation of cultural respect and knowledge. For example, there needs to be recognition of mechanisms for harm for children, young people and families who have experienced racism and oppression, in addition to the intrafamilial trauma associated with violence, abuse and neglect. These are often connected parts of an intergenerational legacy.

There are additional mechanisms for change that may be available for Aboriginal children and young people, such as finding a connection to culture and community as part of strengthening identity. Cultural knowledge can inform other mechanisms for change, and provide examples of appropriate interventions for Aboriginal children, young people and families. Caution needs to be taken so as not to oversimplify cultural practices, and is another reason why cultural consultation is essential.

Cultural safety is a key component in undertaking assessment with Aboriginal families. One of the first things to establish is a family's cultural identity or identities, and whether one or more family members identify as being Aboriginal. However, caution must be taken when queries are raised in relation to the cultural identity of clients and their family. Historically, many Aboriginal people and communities were denied their cultural identity and forced to disown their Aboriginality through child welfare practices and assimilation. Therefore it is vital that as a service in a perceived position of power, CPCS actively seek to empower clients in exploring their cultural identity, and avoid making assumptions.

A complex aspect of assessment is appropriately assessing an Aboriginal child/young person's attachment with their family/carers. Few studies on attachment have included Aboriginal children. Attachment theory has largely evolved from Western constructs, and therefore its application to collectivist cultures including Aboriginal cultures requires caution. For example, Aboriginal children/young people may seek an attachment network with a deep sense of belonging, rather than focusing on one or two carers (Coade, Downey, MacClung, & Dwyer, 2008).

Attachment behaviours, such as when and how a child seeks comfort and encouragement from an adult, are found across all cultures. However, attachment can only be interpreted properly within a cultural context (Jackson et al., 2013). It is crucial for each CPCS counsellor to be mindful of their own cultural reference and the assumptions that can flow from that. This is discussed in more detail in Appendices 6 and 7 on the CPCS theoretical and practice frameworks.

Another aspect of assessment is considering the impact of trans-generational trauma on the child/young person, parents, extended family and community. This may include a

family member being one of the Stolen Generations, the removal of children, high rates of suicide, systematic and direct racism, oppression, acculturation and widespread grief and loss. Although many children and families involved in Child Protection will have experienced multiple generations of trauma and deprivation, Aboriginal communities have experienced this in a systemic and community-wide basis as a part of government policy. It requires vigilance and a concerted effort from the service system, including CPCS counsellors, to not repeat policy and practice mistakes of the past.

When the child or adult seems ready to explore their own history, such as that of trauma and loss, this is always a time of reflection and careful and considered engagement. This is no less the case when working with Aboriginal children, young people and families. Suggestions on how to help Aboriginal children tell the story of the past include:

- Create opportunities to talk about loss and grief experiences, such as being removed from their family or community, having a child removed from their care, death in the family or the losses associated with leaving a placement.
- Help them put their thoughts and feelings into their own words.
- Use more than words, such as art therapy and music so it makes sense to them.
- Understand other trauma that may have happened with their family and community.
- Recognise community and cultural trauma and its impact.
- Find others in their social networks they can trust to hear and witness their story.
- Realise they can talk about their story without shame (Coade et al., 2008).

Another important element in telling their story, especially from a community and cultural perspective, is to acknowledge and pay respect to the warriors and heroes in their community both in the present and past. This helps children, young people and families to honour their own journey of recovery and survival, especially if they have stories where they have helped others along the way (Jackson et al., 2013, p. 47).

Other consideration for CPCS interventions practice with Aboriginal children, young people, families and communities include:

- Supporting Aboriginal children, young people and families who have experienced trauma to regain control and decision-making over all aspects of their lives by providing information about CPCS, interventions and their involvement in the care and protection system.
- Ensure that therapeutic interventions are holistic and strengthen family and kinship connections, including involving extended family members where appropriate.
- Develop respectful therapeutic relationships that are strengths-based and focus on the capabilities that individuals and families bring to their healing and recovery.
- Demonstrate an understanding of kinship, appreciating that the concept of family is not exclusive to blood-line and is not only in relation to a placement option.

- Demonstrate an understanding that various family members may play a significant role in the rearing and parenting of children and young people.
- Help parents/carers realise their own parent/carers' experience of trauma, when appropriate, and provide a cultural trauma lens for understanding their family history.
- Adopt practices that demonstrate respect for Aboriginal cultural backgrounds such as use of cultural rituals, first language and kinship boundaries.
- When working with Aboriginal children, young people and families who may be disconnected from culture and identity, consult with local Aboriginal services about how to support positive connections.
- Consult with family and Aboriginal workers regarding possibility of supporting a 'return to country'. This can be for children, young people and families who have strong connections to their country but are no longer living there, as well as for those who may be discovering their country for the first time. This must be done sensitively and led through an Aboriginal organisation.

8.3 Community engagement

Engagement with local Aboriginal communities is a core part of CPCS work and is essential in achieving positive outcomes for the children, young people and families who come to CPCS for support. Community engagement involves earning and gaining a community's trust and respect, and working towards collaboration with the community around the safety and wellbeing of the community and its children and young people. Without this trust and respect, CPCS may find that any attempt at providing a service to local Aboriginal communities will not be effective.

As outlined above, community engagement or *reaching out*, should only be undertaken when an organisation and its staff have carefully taken the steps of *becoming informed* and *taking a stance* (Herring et al., 2013). Community engagement involves creating, developing and sustaining relationships with Aboriginal people and communities based on trust, safety, respect and transparency.

Community engagement for CPCS may look different for each service due to the different geographical, social, and cultural contexts of each service. Each CPCS will also have its own style of management and composition of staff and practitioners, which will have a bearing on the way community engagement happens in that area. Community engagement is a deliberate and planned activity of CPCS. Planning, activity and outcomes connected to the core purpose of CPCS should be recorded and reported on together with reports of direct clinical services.

The CPCS are also part of the broader violence prevention and response provided by Local Health Districts, and as such will also contribute to the community engagement process undertaken in its local area. In accordance with this overall response, the CPCS proactively and respectfully engage with Aboriginal communities in developing effective service responses with children and families. CPCS will need to work in concert with the

overall Local Health District strategy so as not to increase the burden of Aboriginal organisations in terms of attendance at meetings and processes.

Community engagement can include:

- Information-sharing with Aboriginal families and communities about CPCS and mainstream services and how to navigate them that is in accessible language and formats.
- Supporting Aboriginal families and communities to understand their rights within CPCS, and other mainstream system/s, and advocating for them around these rights.
- Supporting families and communities on their journey of supporting their child/young person who is attending CPCS.
- As part of an interagency response, supporting families and communities to manage the impacts of inter-generational trauma and oppression, e.g. Stolen Generations, removal of Aboriginal children/young people.
- Working with Aboriginal communities to consider key training messages from relevant community organisations, regarding current and inter-generational trauma and oppression, e.g. impact of Stolen Generations, removal of Aboriginal children/young people and colonisation
- Linking children and families with local Aboriginal community or Aboriginal organisations, especially when they are not already connected to culture and community.

Consequences of not prioritising community engagement can include potential damage to relationships between CPCS and local communities, lack of awareness about local communities, and the isolation of other workers in small communities relying on CPCS counsellors for support.

Community engagement is a whole-of-service responsibility carried by all CPCS counsellors. All staff are accountable for their participation and commitment to community engagement and development activities with Aboriginal children, young people and their family/carers and communities. As with the development of cultural competence in the service, CPCS managers and clinical leads play a key role in supporting CPCS counsellors to effectively reach out to Aboriginal communities, and ensure that time and resources are made available for this purpose. CPCS managers and clinical leads facilitate discussions with the team to explore and document issues such as:

- Roles and responsibilities of the CPCS staff, and what is understood about these.
- Identifying and prioritising specific communities.
- Learning about the strengths and needs of the communities.
- Identifying existing contacts within the communities or people that can facilitate contact.
- Contacting the communities.

- Seeking the views of the communities and various community members.
- Risks/barriers that might exist and how to address these.
- Identifying issues to address.
- Making a plan to address the issues. This includes identifying what activities need to take place and the frequency of these activities as well as what reciprocal relationships are possible where each contributes in some way to the other, such as with Aboriginal organisations.
- Implementing the plan.
- Seeking feedback from the communities about outcomes.

When engaging with local Aboriginal communities, CPCS counsellors are respectful of cultural protocols and practices. Consideration is given to dress code and the appropriate use of language and body language, and counsellors are mindful of competing demands on the time of Aboriginal people who are involved in organising the engagement activities in their communities. Respect is shown to Elders and other leaders in the communities. Care and respect is shown when a community has Sorry Business, by following local protocols and providing respectful space to the community. As stated by Herring et al. (2013), reaching out can begin by providing offers of support and resources, rather than awaiting requests from the Aboriginal communities.

8.4 Seeking Aboriginal consultation

Aboriginal cultural consultation is a process where a non-Aboriginal worker seeks the advice and guidance of an Aboriginal worker in their work with an Aboriginal child/young person and their family/carers. It may also involve the Aboriginal worker consulting directly with the child/young person and their family/carer regarding the child/young person's culture or identity. If there are Aboriginal workers in the CPCS team, they may be in a position to co-work or provide direct consultation with the child/young person and their family, community or caregiver.

Consultation is an important way of valuing, respecting and learning from the cultural expertise of Aboriginal people, and of supporting Aboriginal children and young people to connect to or remain connected to their culture. Prioritising and respecting Aboriginal cultural consultation recognises that there are Aboriginal worldviews that differ greatly from non-Aboriginal perspectives, particularly in relation to family and kinship systems, as opposed to the non-Aboriginal focus on the nuclear family. It also recognises that many traditional customary laws continue to exist and remain strong in Aboriginal families and communities. It is essential that non-Aboriginal workers consult with Aboriginal workers about these issues in order to make informed decisions and practice in an ethical way. It also enables Aboriginal children and young people and their family/carers to make informed decisions about their futures.

Cultural consultation is aimed at supporting Aboriginal children/young people and their family/carers to maintain or develop cultural connection, understanding the importance of connection to family, community and country to a child/young person's identity, social and emotional wellbeing. Family may be a healing agent on its own and children/young

people must be supported to connect with family where possible. The significance of Aboriginal Elders in an Aboriginal child/young person's life is recognised and it may be appropriate to involve an Elder/s in the care of the child/young person. However, the privacy and confidentiality of the child/young person within their community must be taken into consideration. Aboriginal people have been nurturing each other for thousands of years, and Aboriginal family systems provide many of the ingredients of the Western view of the therapeutic relationship, e.g. hope, integrity, relationship, trust and rhythm. Connection to culture is a part of an Aboriginal child/young person's identity and their understanding of where they are from and where they are situated in the world.

The first and routine part of consultation occurs within CPCS teams from the time of referral. This is the process of non-Aboriginal CPCS counsellors seeking advice and guidance from Aboriginal CPCS counsellors where available. The advice is generally recorded at team intake and clinical meetings but may be sought at any time assistance is required.

A direct Aboriginal cultural consultation should be undertaken for all Aboriginal children/young people engaged in the CPCS and their family/carers, where they consent to this taking place. The following guidelines can be useful in assisting CPCS counsellors to ensure that appropriate cultural consultation occurs, and should be read in conjunction with the *Template to record Aboriginal cultural consultation* at Appendix 11:

- An Aboriginal child/young person and their family/carers are informed of the practice of cultural consultation at their first meeting with CPCS.
- The wishes of the Aboriginal child/young person and their family/carers in relation to cultural consultation are explored and recorded during the assessment phase, and a plan is developed for meeting these wishes.
- In some circumstances, cultural consultation may be provided by an Aboriginal worker from outside the service. This may be arranged when the Aboriginal worker is unavailable, there is no Aboriginal worker, or another worker is more relevant to the child/young person's needs at the time.
- CPCS should request copies of cultural plans from the referrer and the documents or records of attempts to obtain these documents are kept on the client's file.
- CPCS should work within the context of the child/young person's cultural plan, and aim to support the strengthening of the child/young person's cultural identity and connections as a means to building health and wellbeing.
- Cultural consultation takes place at key points during the child/young person's journey, e.g. assessment phase, change in circumstance (e.g. carer, significant event, death/Sorry Business), and prior to any significant decision-making occurring in relation to the child/young person or their family/carers. At a minimum, consultation should take place during the review period every four months. An *Aboriginal consultation cover sheet* (see Appendix 13) is placed at or near the front of the child/young person's file to provide an accessible overview of cultural consultations for the child/young person and their family/carers.

- Consultation should take place when therapeutic interventions or other aspects of the work are not progressing well, or there is deterioration or increased risk in the child/young person's situation.
- In most instances, consultation meetings occur face to face or, alternatively and after negotiation, via telephone, teleconference or videoconference. Consultations are scheduled and planned, and a brief summary of the family history is provided to the Aboriginal worker prior to the consultation to allow them the opportunity to declare a conflict of interest.
- Where an Aboriginal worker identifies a conflict of interest, the CPCS manager and clinical lead should support the worker and the family to come to a collective decision on how this will be managed. Collaboration is required with local Aboriginal Family Wellbeing and Violence Prevention Workers and Aboriginal workers from other organisations.
- Each consultation is documented by negotiation with all parties using the *Template to record Aboriginal cultural consultation (*see Appendix 11) or an equivalent local form, signed by all parties and filed in the child/young person's file (or that of their family/caregivers).

Non-Aboriginal CPCS counsellors will consult closely with Aboriginal CPCS workers when working with Aboriginal children, young people and their families to ensure cultural safety. Where possible, and where the family consents, all families where there is a family member/s who identify as Aboriginal will be able to speak with an Aboriginal worker to discuss Aboriginal cultural issues, even though the primary therapeutic engagement may be with a non-Aboriginal worker. Where appropriate, feedback will be provided by the Aboriginal worker to the non-Aboriginal worker/s working with the family. Consultation may take place around issues such as verbal and non-verbal communication, cultural protocols, potential barriers to progression in therapy (which may be to do with service provision, cultural issues or other issues), and planning of client pathways and sessions.

CPCS managers and clinical leads are responsible for overseeing the practice of Aboriginal consultation within the team, and will have systems in place to ensure non-Aboriginal CPCS workers' engagement in Aboriginal consultation, and to support Aboriginal CPCS workers in their work around cultural consultation.

8.5 Aboriginal workforce

NSW Health acknowledges the value and importance of employing Aboriginal practitioners within Health services. It recognises the impact of colonisation, racism, oppression, persecution and trauma on Aboriginal workers, and the dynamics of power and privilege in the work and in the workplace, and supports Aboriginal practitioners to navigate this journey.

Developing, supporting and learning from an Aboriginal workforce within CPCS, with due consideration to ensure their cultural safety, is vital for effective work with Aboriginal

children, young people, families and communities. This includes supporting the access of Aboriginal workers to cultural leadership, and recognising cultural knowledge in practice.

In addition to recruiting qualified Aboriginal workers into current positions, each CPCS team should aim to have at least one identified Aboriginal position in which workers are brought on as a trainee while completing the Education Centre Against Violence (ECAV) Aboriginal Qualification Pathway. Once a trainee has finished the Pathway and is no longer a trainee, the potential for employment within the service, or the broader Local Health District should be explored, allowing for recruitment of another Aboriginal trainee.

NSW Health highly values the cultural expertise, skills, knowledge and abilities of Aboriginal practitioners, and ensures that Aboriginal practitioners are able to demonstrate this cultural expertise, skill, knowledge and ability.

The CPCS remains committed to the provision of cultural supervision, development and training for Aboriginal practitioners. Current options/arrangements for cultural supervisors include through:

- NSW Health;
- ECAV; and/or
- external cultural supervisors.

Possible options for delivery of appropriate cultural supervision for CPCS may include:

- Whole-of-team cultural supervision, quarterly.
- Managers, one hour, every two months.
- Aboriginal practitioners, one hour, monthly.

NSW Health is committed to supporting Aboriginal counsellors to attend relevant Aboriginal Counsellors Network meetings.

Part Three: Child Protection Counselling Services management

9 Information-sharing and client records

The way client information is gathered, recorded, stored and shared is fundamental to professional clinical practice. From referral through to assessment, case formulation, case planning, therapeutic intervention and closure, information is gathered and interpreted to gain insight into the child/young person, parent(s)/carers' experience, and to guide the process. Information about a person belongs to that person. A quality clinical service only has access to such information on the understanding it is gathered purposefully and in a way to safeguard accuracy, treated with respect and shared with others when needed to enhance the safety and wellbeing of the individual. Subject to the relevant legislative and policy framework, the child/young person's best interests should inform how records are kept and how and when information is shared.

9.1 Client records

CPCS is required to comply with the NSW Health Policy Directive on *Health Care Records — Documentation and Management*, which is the primary reference point for CPCS regarding client records. Below is a summary of the key elements of that Policy Directive as they relate to a CPCS context as well as identifying any additional elements to consider with regards to client records.

Client records are used to promote client safety, continuity of service, and support the transfer of information when a case is transferred from one worker or team to another. Client records provide an important role in review, such as when a child/young person's situation is deteriorating or other difficulties arise.

The following guidelines apply to client records:

- CPCS will maintain record management systems in accordance with the policies set out in on *Health Care Records — Documentation and Management*
- Where a client discloses an experience of sexual assault, CPCS are aware of the function of the Sexual Assault Communications Privilege with respect to access to, and subpoena of, counselling records. Staff will ensure they respond to the subpoena in accordance with NSW Health policy on Subpoenas.
- CPCS will inform clients whose counselling records have been subpoenaed of the services provided by the Sexual Assault Communication Privilege Unit in NSW Legal Aid at http://www.legalaid.nsw.gov.au/what-we-do/civil-law/sexual-assault-communications-privilege-service and how they will be supported by CPCS.
- Communication privilege does not apply within the Family Court (refer to NSW Health policy on Subpoenas).

9.1.1 Hard copy files

Where hard copy files are utilised in CPCS, these will be securely stored and retained in accordance with NSW Health and Local Health District policies and procedures as well as legislative requirements. Clients accept CPCS interventions on the understanding that within statutory limitations, they are attending a confidential service. Clients have a right to know that records are secure and that they will be securely stored for a requisite period of time following their attendance at the service.

9.1.1 Electronic clinical record systems

Where the CPCS utilise an electronic record system, every CPCS will complete the electronic clinical documentation as appropriate for every new client and all subsequent client contact.

9.1.2 Content of client files

CPCS will maintain comprehensive client records that provide an accurate description of each client's episodes of service. A client record must be created and available for every client to assist with assessment, case formulation, case planning, therapeutic intervention, continuity of care, clinical handover, client safety and clinical quality improvement, education, research, evaluation, medico-legal, funding and statutory requirements.

Where interventions involve multiple family members, the same case note will be saved on each relevant person's client file. Similarly, reports that relate to all clients in the family will be saved on each file.

CPCS will enter information on the client record including client contact details, (including phone contact), and communications with family members or other services. This is guided by the CPCS Data Dictionary for data collection.

The client record will include a range of information gathered over time. Overall the file will document the following at a minimum:

- Client name, date of birth, current address.
- Date, time and place of presentation.
- Background to referral, name of referrer and contact details.
- Contact details of child/young person, family and carers.
- Referral record.
- Aboriginality status when the client identifies as an Aboriginal or Torres Strait Islander person.
- Family structure and key relationships.
- History including of protective concerns and any other relevant information.
- Past and current safety issues for the child/young person or family.
- Strengths and resources.

- Information about the presence and impact of violence, abuse, and/or neglect on the client/s.
- A record of any contact with Family and Community Services (FACS), schools, and any other agencies.
- NSW Police Force or Joint Child Protection Response Program involvement
- Information relevant to worker safety.
- Assessment, review and closure reports.
- Intervention Plan.
- Cultural information, such as regarding identity, connection, belonging and language.
- Issues that might compromise consent or require further arrangements, e.g. cognitive impairment, mobility issues, mental health issues, drug and alcohol intoxication or withdrawal, need for interpreter, etc.
- Case notes.
- Letters or emails sent and received

9.1.3 Security and confidentiality of records

CPCS will ensure that systems are in place to ensure confidentiality of client files in accordance with NSW Health Policy Directives including, but not limited to, the *Privacy Manual for Health Information* and the *Privacy Management Plan*.

CPCS clients and their family/carers will be made aware of policy and legal directives that may impact on client confidentiality and the circumstances in which health information may be disclosed, including:

- Where necessary, to protect the person's safety.
- Mandatory reporting where a child/young person is believed to be at risk of significant harm.
- Subpoenaing of notes and medical records.

Children and young people have the right to privacy of their health information and to make their own decisions regarding their privacy where they are competent to do so. Parents, carers and guardians do not have automatic access to all health information relating to a child or young person in their care.

The NSW Health *Privacy Manual for Health Information* notes certain differences for CPCS records compared to other health records with respect to restricting access to records. These include a requirement that:

- CPCS client records be generally maintained separately from the general health record;
- CPCS records can only be linked to the general health record via a notation that a "*confidential health record exists*"; and

- Access to CPCS client records is restricted and can only be accessed via a designated contact within CPCS, who will seek the client's consent first.

Access to CPCS records will be restricted to the following:

- CPCS staff and management;
- staff involved in client safety, the investigation of complaints, audit activities or research (subject to ethics committee approval, as required);
- a client to whom the record relates, or their authorised agent, based on a case by case basis in accordance with health service release of information policies and privacy laws; and
- other personnel/organisations/individuals in accordance with a court subpoena, statutory authority, valid search warrant, coronial summons, or other lawful order authorised by legislation, common law or NSW Health policy.

9.1.4 Record retention

CPCS will retain hard copy and electronic copies of client files according to the NSW Government's policy on *Health Services, Public: Patient/Client records*,[6] which requires:

- records are to be retained for a minimum of 30 years after any legal action is completed and resolved (where known) or after last contact for legal access, or
- records are to be retained for 30 years after the individual attains or would have attained the age of 18, whichever is the longer, and
- then destroy.

9.2 Information-sharing and privacy

9.2.1 Privacy

All NSW Health services must collect, use and disclose health and personal information in accordance with NSW privacy legislation, particularly the *Health Records and Information Privacy Act 2002* (*HRIP Act).*

Under the *HRIP Act*, health information is personal information (identifying information, such as name or address) or an opinion about:

- a person's physical or mental health or disability; or
- a person's express wishes about the future provision of health services for themselves; or
- a health service provided, or to be provided to a person.

[6] See also: http://www.records.nsw.gov.au/recordkeeping/rules/retention-and-disposal-authorities/general-retention-and-disposal-authorities/public-health-services-patient-client-records-gda17/part-1-the-general-retention-and-disposal/1.0.0-patient-client-treatment-and-care

Generally speaking, any personal information that is collected for the purposes of the provision of health care will be 'health information'.

The *HRIP Act* contains 15 principles that govern how health services must deal with health information. The principles include how information is to be collected, stored, used and disclosed.

CPCS will maintain and protect the privacy of children/young people and their families/carers in accordance with privacy legislation and NSW Health policies, specifically the *Privacy Manual for Health Information* and the *Privacy Management Plan*.

9.2.2 Limited confidentiality

Under the *HRIP Act*, information can only be disclosed when permitted by the principles in the *HRIP Act* or under other lawful circumstances (a lawful excuse). Subject to the specific provisions in the HRIP Act, the general circumstances where the disclosure of health information is permitted include:

- With consent.
- Where the disclosure is directly related to the purpose for which it was collected.
- Where there is a serious threat to health or safety of a person.
- For training.
- For research.
- For the purpose of law enforcement.

A lawful excuse to disclose health information would include information disclosed to a court under a subpoena.

There are some additional obligations on staff to disclose health information, namely under Section 27 and Chapter 16A of the *Children and Young Persons Care and Protection Act 1998 (the Care Act)* (See section *9.2.3 Information-sharing under Chapter 16A of the Care Act)* and Section 316 of the *Crimes Act 1900*.

Section 27 of the *Care Act* requires mandatory reporting where a person suspects, on reasonable grounds, that a child under 16, or a class of children, are at risk of significant harm (ROSH). ROSH is defined under Section 23 of the *Care Act* and requires current concerns for the safety, welfare or wellbeing of the child or young person because of the existence of one or more circumstances. Refer also to Section 9.3 below for more detail on ROSH and the process of reporting to FACS. More information on mandatory reporting can also be found in the *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*.

The *Crimes Act 1900* creates an obligation to share information with NSW Police if a person has information about a 'serious indictable offence' (section 316) or a 'child abuse offence' (section 316A), and the information might be of material assistance to police in apprehending, prosecuting or convicting the offender. A serious indictable offence is an offence that carries a term of imprisonment for five years or more and includes any form of assault that causes actual bodily harm, including scratches and bruises. A 'child abuse

offence' under the *Crimes Act 1900* includes serious physical as well as sexual abuse of a child under the age of 18 years.

These legal obligations do not require NSW Health workers to report information about a child abuse offence to police if they have already reported the information to the Child Protection Helpline or NSW Health Child Wellbeing Unit, or they believe on reasonable grounds that another person has. This is a 'reasonable excuse' for not reporting the information to police. NSW Health staff do have reporting obligations where the allegation is against another NSW Health worker (see Section 9.4 for more details).

Other examples of reasonable excuses for not reporting the information about a 'child abuse offence' to Police include:

- Knowing or reasonably believing that the information is already known to police.
- If the alleged victim is an adult at the time of providing the information and doesn't want it reported to the police.
- The person has grounds to fear for their safety or another person's safety if they report to police.

Persons failing to report a 'serious indictable offence' or 'child abuse offence' to police without a reasonable excuse may be liable to imprisonment for two years, or five years if the person receives any benefit for concealing the offence. However prosecutions cannot be sought against the professions prescribed in the *Crimes Regulation 2015* (which includes a medical practitioner, psychologist, nurse, social worker, support worker for victims of crime, and counsellor who treats persons for emotional or psychological conditions suffered by them) without the consent of the NSW Director of Public Prosecutions, if that information was obtained while undertaking their role.

CPCS staff will inform children/young people and their family/caregivers about privacy and limited confidentiality, namely that their information may be shared with third parties (such as Family and Community Services [FACS], NSW Police and other agencies) where necessary to ensure the safety and wellbeing of a child, or when required by law. The following guidelines apply to limited confidentiality:

- Information about limited confidentiality will be provided at the first point of contact, and revisited during the assessment and other interventions as appropriate.
- Where a new or additional family member/carer becomes involved, CPCS workers will inform them of limited confidentiality as above.

9.2.3 Information-sharing under Chapter 16A of the *Care Act*

In addition to the provisions in Section 27, Chapter 16A of the *Children and Young Persons Care and Protection Act 1998 (Care Act)* creates a legal mechanism for the sharing of information when requested by a prescribed body. Information shared in accordance with Chapter 16A is a lawful excuse for the purposes of *Health Records and Information Privacy Act 2002* (*HRIP Act*) (as discussed above).

A prescribed body includes the NSW Police Force, a Public Service agency or a public authority.[7]

CPCS should provide information relating to the safety, welfare or wellbeing of a particular child or young person or class of children or young people to another prescribed body if CPCS staff reasonably believe that the provision of the information would assist the recipient to:

- Make any decision, assessment or plan or to initiate or conduct any investigation, or to provide any service, relating to the safety, welfare or wellbeing of the child or young person or class of children or young people; or
- Manage any risk to the child or young person (or class of children or young persons) that might arise in the recipient's capacity as an employer or designated agency. This includes providing sufficient information to meet that employer's obligations under the NSW *Ombudsman Act 1974* (refer also to Section 9.4 and Appendix 4).

CPCS should proactively share information where it meets the requirements under Chapter 16A of the *Care Act*, even where another prescribed body has not specifically requested access to that information.

Chapter 16A does not create a right for the requesting prescribed body to have access to all records of a client. Rather only records that fall within the scope of Chapter 16A referred to above are lawfully authorised to be disclosed under the *Care Act*. The *HRIP Act* will continue to apply to records not captured under the request. Inadvertent disclosure of information not covered by 16A could be a breach of the *HRIP Act*.

Further, while information disclosed under Chapter 16A may be used for investigations, the intention of the Chapter is not for evidence gathering purposes for a criminal prosecution (which would instead be obtained by another process, such as by subpoena).

CPCS workers will review any request for information under Chapter 16A of the *Care Act* to ensure that the request is appropriate and if so, identify what CPCS records are relevant to the request. Where a requesting agency is not aware what records are held by CPCS, the request might be too broad. In these circumstances CPCS workers will speak to the contact person at the requesting agency to assist in identifying what records are needed.

Further information about information-sharing under the *Care Act* is available at *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*.

[7] Prescribed bodies are defined in section 248 of the *Care Act*.

9.2.4 Information-sharing under Chapter 13A of the *Crimes (Domestic and Personal Violence) Act 2007*

Part 13A of the *Crimes (Domestic and Personal Violence) Act 2007* (the Act) allows the sharing of information in certain circumstances related to domestic violence and has effect despite any provision under the NSW privacy legislation. In particular, in the case of a serious domestic violence threat[8] an agency[9] may, despite the privacy legislation, deal with (collect, use or disclosure) information about a person without the consent of the person if the agency believes on reasonable grounds that:

a) the particular dealing is necessary to prevent or lessen a domestic violence threat to the person or any other person; and
b) the threat is a serious threat; and
c) the person has refused to give consent or it is unreasonable or impractical to obtain the person's consent.

If an agency believes on reasonable grounds that a person (the 'threatened person' as defined by the Act) is subject to a domestic violence threat (i.e. not a *serious* threat), Part 13A allows that agency to disclose personal information and health information about the threatened person and any person that the agency reasonably believes is a cause of the threat (the 'threatening person' as defined by the Act) to the central referral point or a local coordination point for contact purposes. This disclosure requires the consent of the threatened person, but not the consent of the threatening person.

The *Domestic Violence Information-sharing Protocol* (the Protocol) under the NSW Government's *Safer Pathway* explains how information may be shared in accordance with Part 13A of the Act. NSW Health staff should refer to the Protocol to guide their decision-making. Other resources which may also be of value in assisting to guide NSW Health staff in their decision-making around these issues are available on the *Safer Pathway* website and include the *Domestic Violence Safety Assessment Tool (DVSAT)* to assess the level of threat, *Information-sharing process flowchart*, *Information-sharing consent flowchart*, *Consent form*, and a *Fact sheet for victims*.

9.2.5 Process for information-sharing and access to files

Caution should be applied to verify the identity of people receiving information. For example, when the CPCS worker does not know the person who is seeking information they should be confident that the person is who he or she claims to be before providing such information. Particular strategies may include the following:

- Enquiries made by telephone regarding information in relation to a client's contact with CPCS, or regarding the outcome of a visit, will only be responded to by verifying the identity of the caller or asking them to submit the request in writing.

[8] Where 'threat' is defined in the Act as a threat to the life, health or safety of a person that occurs because of the commission or possible commission of a domestic violence offence (where the types of offences and relationship between parties are specified further in the Act).
[9] Defined in the Act as a public sector agency within the meaning of the *Privacy and Personal Information Protection Act 1998*, or an organisation within the meaning of the *Health Records and Information Privacy Act 2002* to which that Act applies.

- To verify the identity of the caller, CPCS workers should ask for the caller's telephone number, verify the number given is that of the caller's workplace and telephone the caller back to give the required information, if assessed as appropriate.
- Client consent will be obtained prior to transmission of information where possible. A copy of that consent should be kept in the client's records
- Any client information sent via email should be done so in accordance with *Privacy Manual for Health Information*. The CPCS worker will ensure that they have the correct email address for any electronic communication. Encryption should be considered for emailed information.

Particular caution is required regarding sharing information from one family member to another. There may be issues of hidden domestic and family violence, family secrets or other pitfalls that a practitioner could make worse through not knowing the back story. The CPCS counsellor should not be a conduit to passing information between one parent and another without their direct involvement and consent.

Procedures will also be in place to enable clients to have safe and secure access to their own files.

9.3 Reporting to the FACS Child Protection Helpline

9.3.1 General guidelines

Risk of significant harm refers to where current concerns exist for the safety, welfare or wellbeing of the child or young person because of the presence, to a significant extent, of any one or more of the circumstances detailed in Section 23 of the *Children and Young Persons (Care and Protection) Act 1998*. These circumstances include the likelihood that a child or young person may suffer physical, psychological or emotional harm as a result of what is done (e.g. physical, sexual, emotional abuse or living in a household where there is domestic violence) or not done (e.g. neglect) to the child or young person by another person, often an adult responsible for their care. Risk of significant harm can also refer to a child or young person who may suffer physical, psychological, sexual or emotional harm as a result of environmental factors (e.g. homelessness) or self-harming behaviours.

Where a NSW Health worker has reasonable grounds to suspect that a child or young person is at risk of significant harm, Section 27 of the *Children and Young Persons (Care and Protection) Act 1998* (the *Care Act*) requires them to make a report to the Child Protection Helpline.

Prior to making a report, NSW Health workers should consult the online Mandatory Reporter Guide (MRG), on the ChildStory website, because following the MRG outcome has been shown to increases the likelihood of an appropriate ROSH report being made.

Section 27A of the *Care Act* enables NSW Health workers (and certain other mandatory reporters) to report (via telephone or eReport) to the NSW Health Child Wellbeing Unit, as a legal alternative to reporting to the Child Protection Helpline. When a worker reports

concerns to the NSW Health CWU and the CWU appraises that a report to Helpline is indicated, if agreed, the CWU may eReport directly on the health worker's behalf.

The CPCS service criteria require that the concerns the child/young person is being referred for have been screened in by the Child Protection Helpline as Risk of Significant Harm (see Section 5.1.2). Nevertheless, the child/young person may make further disclosures of abuse or neglect during contact with the CPCS or new information or circumstances may arise which may make the CPCS worker suspect the child/young person is at risk of significant harm.

CPCS workers are required to adhere to the *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* and, in accordance with this, if they suspect a child or young person (or class of children and young people) may be at risk of significant harm, they will:

- Report **to the Child Protection Helpline** any **new disclosures or incidents** of abuse or neglect or any **new information or changes in circumstances** that they suspect may be risk of significant harm if they are unaware whether FACS has this information. In making the report, provide as much information as possible about the child/young person's current circumstances, including safety and the current impact of the new disclosures/incidents of harm on the child/young person, to assist agencies' planning any possible next steps.
- Use professional judgement and apply the *Mandatory Reporter Guide* as a tool to assist in determining whether to report to the Child Protection Helpline (or alternatively to the NSW Health CWU) a child or young person who you suspect may be at risk of significant harm (ROSH).
- Consider who else to consult with when deciding whether a report to the Child Protection Helpline is required. When the child or young person has a FACS or OOHC caseworker and you are unsure whether the information you have is known by them, it is best practice to consult with the casework in the first instance when determining whether a new suspected ROSH report is required. The NSW Health Child Wellbeing Unit (CWU) can also assist in assessing the level of risk and detecting patterns of neglect and/or cumulative harm via their direct access to the shared ChildStory client database, particularly when you are undecided as to whether any new information should be reported.
- Adhere to *Child Related Allegations, Charges and Convictions Against NSW Health staff* where the alleged offender is working or has worked in NSW Health (paid or unpaid).
- If it relates to a registered health professional who does not work in NSW Health, consideration may need to be given to a notification to the Australian Health Practitioner Regulation Agency or the Health Care Complaints Commission.
- Contact the Child Protection Helpline as soon as possible where there are immediate concerns that a child or young person is at risk of significant harm. N.B. You can choose to either telephone the Helpline or eReport via the link on the MRG outcome page.

- Where appropriate, explain to the child or young person and parent or carer (if appropriate and safe to do so) the rationale for the need to report to the Child Protection Helpline. Also explain (if safe and appropriate) that a possible referral to the Joint Child Protection Response Program may occur so that Health, FACS and Police can work together to ensure their current and future safety, health and wellbeing. Note: depending on the nature of risk to the child or young person, it may not be appropriate to advise the family that a report is being made.

9.3.2 Young people aged 16 and 17 years old

Although the *Children and Young Persons (Care and Protection) Act 1998* provides some discretion about reporting young people aged 16 or 17 years old, CPCS workers should complete the MRG and report to the Child Protection Helpline when they suspect the young person aged 16 or 17 years is at risk of significant harm and follow the general guidelines above.

Staff should also consider contacting the Health Child Wellbeing Unit for additional information on ChildStory, since this may reveal a past history relevant to either the victim's current safety and wellbeing or about the alleged perpetrator.

Where a CPCS worker decides not to make a report to the Child Protection Helpline regarding a young person (aged 16 or 17 years), the factors that were considered and the reason for this decision should be documented in the client's file.

When working with a young person aged 16 or 17 years old, CPCS workers should:

- Involve the young person in the decision to make the report and the process of reporting, unless there are exceptional reasons for excluding them.
- When reporting, workers should ensure they provide as much information as possible about the young person's current circumstances, including who is aware of the abuse. This will assist FACS and/or Police in how to proceed with an investigation, including supporting the ongoing safety of the young person. For example, if the young person has not disclosed to any family member sexual abuse that has occurred outside of their household, then it is important that the report includes this information. This will enable investigators to be sensitive to the young person's concerns about who may be informed of the abuse and when this might occur.
- Inform the Child Wellbeing Unit or the Child Protection Helpline if the young person does not agree to the report being made so they can consider the young person's wishes in any investigations and assessments.

9.3.3 Documenting reports to the Child Protection Helpline

A report made to the Child Protection Helpline or to the Child Wellbeing Unit must be documented in the Health record of the child, young person or adult client (e.g. where they are the parent/carer), in accordance with *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*. Documentation regarding the report made to the Child Protection Helpline or CWU should include:

If phone reported:

- The date and time the report was made.
- The name of the caseworker spoken to at the Child Protection Helpline.
- The nature of concerns reported.
- Whether the MRG was completed, and if so, a copy of the MRG outcome decision report.
- The ChildStory Engagement (Reference) Number.
- Any feedback subsequently provided by the Child Protection Helpline and/or FACS.

If eReported:

- A PDF or printout of the full eReport.
- The ChildStory Engagement (reference) Number.
- Any feedback subsequently provided by the Child Protection Helpline via the online eReporter dashboard and/or FACS.

9.3.4 Documenting consultation with the Child Wellbeing Unit

A consultation with, or report to, a NSW Health Child Wellbeing Unit must be documented in the Health record of the child, young person or adult client (e.g. where they are the parent/carer). This documentation should include the date, the name of the Child Wellbeing Unit worker, summary of any advice provided, the outcome/plan at the end of the contact, and the ChildStory Engagement (reference) Number (if provided). N.B. All CWU contacts are documented on ChildStory. A record that a CWU contact occurred about a child or young person (and a short description of the reason for the contact) is visible to FACS caseworkers and to other CWUs. No reporter or full details of CWU reports are open to other agencies, unless a subsequent 16A information exchange deems this appropriate.

9.4 Reporting allegations, charges and convictions against a NSW Health worker that relate to children and young people

CPCS staff members must immediately notify the Chief Executive (or delegate) of the relevant NSW Health organisation (e.g. Local Health District) through the appropriate management processes of any allegation, charge or conviction against a NSW Health worker that involves a child or young person. This notification would usually be through the relevant Workforce Director or equivalent.

This includes:

- alleged physical or emotional abuse, neglect, exposure to domestic and family violence; alleged grooming, physical or sexual assault; or alleged offences involving child abuse material;
- work and non-work related and/or historical allegations even where the child or young person is now an adult.

Allegations relating to conduct that occurred within NSW Health by a worker who is not engaged in NSW Health at the time of receipt of the information must still be notified to the relevant Chief Executive.

CPCS staff will adhere to NSW Health's policies on responding to allegations against NSW Health workers and reporting child protection concerns. This includes *Child Related Allegations, Charges and Convictions against NSW Health Staff*; *Managing Misconduct*; *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*; and the *NSW Health Policy on Managing Complaints and Concerns about Clinicians*.

Child Related Allegations, Charges and Convictions against NSW Health Staff provides guidance on mandatory obligations for NSW Health staff in these circumstances, which includes notification and reporting to the following agencies as relevant:

- Child Protection Helpline (see Section 9.3 of this Policy Directive).
- Child Wellbeing Unit.
- NSW Police Force (for any alleged criminal conduct)
- Employing Chief Executive.
- NSW Ministry of Health.
- NSW Ombudsman.
- Office of the Children's Guardian.
- Australian Health Practitioner Registration Agency.

This policy also provides detailed guidance on risk management, investigating, responding to, and recording child/young person-related allegations, charges and convictions by a NSW Health worker.

Under the *NSW Health Code of Conduct*, it is a requirement of working in NSW Health (whether on a paid or unpaid basis) that staff must:

- Report criminal charges and convictions against them involving offences punishable by imprisonment for 12 months or more to their Chief Executive within seven days of the charge being laid or a conviction recorded
- Report to the designated person within their Health organisation, upon becoming aware of an allegation, charge or conviction involving an under-18 year old against another NSW Health staff member

9.5 Subpoenas

CPCS will respond to subpoenas in accordance with the NSW Health Policy Directive *Subpoenas*.

All subpoenas are processed by the Local Health District's Records Unit. This unit will look at the subpoena to check it is properly filed with the court, properly addressed to the Local Health District and contains the usual legal requirements. If it is not properly filed, the Records Unit will follow its process for dealing with deficiencies. It is not the responsibility of CPCS to undertake this task. Once the subpoena has been referred to CPCS, the CPCS worker, manager or clinical lead will determine what information is covered by the subpoena.

CPCS must comply with subpoenas, while taking steps to protect individual's rights to confidentiality. For example, CPCS workers may take steps to protect confidential communications and sensitive material, while complying with the terms of the subpoena.

In all circumstances CPCS or other staff in the Local Health District should attempt to contact the client and family/carers to advise that their records have been subpoenaed. When the child/young person and family/carer are a current CPCS client, the CPCS worker will usually be the appropriate person to inform them of the subpoena. The client should be advised of what is covered by the subpoena. The client should also be informed about the location and date of return of the subpoena (care should be taken that the records are not inadvertently given to the lawyers before that date) as they may wish to object to it.

If a CPCS staff member has concerns about the scope of a subpoena, or considers it may be challenged, he or she should consult their immediate manager. Where a CPCS worker has concerns about a subpoena or the records that are to be produced, the worker should contact Legal and Regulatory Services at the Ministry of Health.

9.6 Sexual assault communications privilege

The *Sexual Assault Communications Privilege* (SACP) limits disclosure of counselling, health and other therapeutic information about a victim of sexual assault. SACP is a protection for counselling communications to or about a victim or alleged victim of a sexual assault offence, from being used as evidence in criminal proceedings, regardless of when that counselling may have occurred. Further information, including guidelines that apply to NSW Health staff in relation to SACP and suggested steps to deal with subpoenas that can contain SACP, is provided about SACP in the NSW Health Policy Directive *Subpoenas.* The Legal and Regulatory Services Branch at the Ministry of Health can also provide specific advice in individual cases.

10 Governance and management

10.1 Data collection and reporting

CPCS staff should refer to the relevant NSW Health Policy Directives, Information Bulletins, Guidelines and policy direction below in relation to data collection and reporting:

- *Registration of NSW Health Establishments:* This Policy Directive describes the mandatory requirement to register health establishment locations and service units within NSW, and record the registration details in NSW Health's, Health Establishment Registration Online (HERO) and release an extract to HealthDirect Australia to populate the National Health Service Directory.

- *Client Registration Policy*: The purpose of this policy directive is to specify NSW Health policy in relation to the registration of clients, patients and other related people.

- *NSW Health Client Data Stream Data Dictionary:* Outlines the data elements and classifications for collection, as represented within the Client Shared Dimensions of the Enterprise Data Warehouse (EDW).

- *Individual Service Provider Data Stream:* Outlines the data elements and classifications for collection, as represented within the ISP Shared Dimensions of the Enterprise Data Warehouse (EDW).

- *Non-Admitted Patient Data Collection: Classification and Code Standards from 1 July 2017:* The purpose of this information bulletin is to inform NSW Health service providers and source system administrators of changes to the classification and code set standard for reporting non-admitted patient services provided from 1 July 2017 in an EDWARD extract format.

- **Other NAP resources:**
  - *Non-Admitted Patient Reporting Rules*
  - *Non-Admitted Patient Establishment Type Definitions Manual*
  - *Non-Admitted Patient Classification Principles*

- **Interim Statewide data collections:** Interim Statewide data collections are required in some instances to allow monitoring and reporting of health services to assist service planning, although they are not mandated by policy. Data collection and reporting arrangements may be discussed with district and network Chief Executives, and/or Tier 2/3 Senior Executives as required. Data may include patient, staff, workforce, organisation, or financial information. While these interim data collections do not meet the definition of a state wide data asset and are not strictly governed by the NSW Health Data Governance Framework, they should seek to adopt best practice approaches and adhere to NSW Health Data Management Principles wherever possible.

- **Whole of Government Reforms:** A number of reporting requirements are emerging as a result of the NSW Government's response to the Royal Commission into Institutional Responses to Child Sexual Abuse, and other cross government initiatives including Their Futures Matter reforms, NSW Sexual Assault Strategy, NSW Ombudsman's review of the JIRT Partnership, and NSW Domestic and Family Violence Blueprint for Reform 2016-2021. These reforms may result in interagency monitoring and reporting frameworks being established that NSW Health reports to.

10.1.1 Service Agreement Key Performance Indicators, Improvement Measures and accountability

The Key Performance Indicator (KPI) and Improvement Measure Data Supplement has been developed to support the Local Health Districts (LHDs)/Specialist Health Networks (SHNs) in monitoring and reporting on Service Agreements by providing the relevant information concerning the calculation of the indicators, as well as other improvement measures as monitored by various Ministry branches. This is updated annually.
Each CPCS will provide the Ministry of Health with routine data against KPIs and Improvement Measures as required under their LHD's Service Agreement for the purpose on performance monitoring and service improvement.

10.2 Service planning and evaluation

Each CPCS is managed by its host Local Health District and will have a management structure in place that clearly delineates the lines of responsibility and accountability of CPCS workers. Each CPCS should have a designated CPCS manager or clinical lead that manages the day-to-day operations of the CPCS.

Each CPCS will conduct service planning on an annual basis. Service planning will:

- involve all staff;
- take a strategic approach;
- enable service delivery that is responsive to the changing needs of the community;
- develop priorities and directions for the coming 12 months;
- take into account value based healthcare by planning to deliver services that improve the health outcomes that matter to patients, the experience of receiving care, the experience of providing care, and the effectiveness and efficiency of care;
- include a workforce plan the includes attention to operational, tactical and strategic planning and which takes into consideration service delivery requirements, models of care and building on workforce capabilities; and
- be undertaken in conjunction with other relevant Local Health District staff.

Each CPCS will:

- Work within their Local Health District to implement quality improvement, planning and evaluation protocols to ensure that services provided are appropriate, of high quality, and effective.
- Participate in, and contribute to, Local Health District planning processes.
- Ensure that CPCS workers, managers and clinical leads have knowledge of local and state issues that arise in the fields of violence, abuse and neglect involving children to achieve effective planning and decision-making.

The CPCS manager, clinical lead and/or workers as appropriate will:

- Consult at local and state levels to ensure service planning and decision-making is well informed and coordinated.
- Participate in relevant Local Health District service evaluation and planning training, and ensure that mechanisms are in place to translate evaluation findings into practice.

10.2.1 Continuous quality improvement

Each CPCS will:

- Use effective and responsive methods to assess and improve the quality of their activities and integrate these systems with their planning and evaluation processes.
- Participate in relevant reviews such as the Australian Health Care Standards (ACHS) Evaluation and Quality Improvement Program (EQuIP), National Safety and Quality Health Service Standards, specific CPCS service reviews by the Ministry of Health or other Local Health District reviews as appropriate.
- Adhere to the NSW Health Policy Directive *Patient Safety and Clinical Quality Program*.

10.3 Complaints

Complaints and feedback may be received at any time during the engagement of CPCS with clients, other services, and communities and so the information provided here is intended to apply across the entire scope of service delivery for NSW Health CPCS.

As with all services, CPCS must be accountable and this includes ensuring that clients (children/young people and their family/carers) have the right to question, in an informal or formal way, the interventions, services and other responses they receive. Similarly, services, community members and others involved with CPCS may also make a complaint. Even when the feedback is not in the form of a complaint, CPCS must ensure it is open to receiving feedback that can inform future service provision.

There must be formal processes for documentation and investigation of complaints to ensure appropriate action is taken and an early response given to the complainant. Where the complaint relates to a child protection report, and there are safety concerns for family members or the reporter, details of people at risk should be de-identified in the client file.

Complaints should be dealt with according to NSW Health's *Complaint Management Policy* and *Complaint Management Guideline*. These outline the processes for trying to resolve the complaint locally, escalating to manager, or offering the complainant to escalate their concerns in accordance with Local Health District based processes and/or to the Health Care Complaints Commission or other relevant organisation when required.

If the complaint concerns a particular CPCS staff member (as opposed to, for example, CPCS policies or approaches generally), policies on *Managing Complaints and Concerns about Clinicians* and *Managing Misconduct* should be consulted.

CPCS clients, if they are victims of crime, also have rights under the *NSW Charter of Victims' Rights*, including their rights to be informed about the complaints process if they perceive that their rights have not been met.

CPCS should inform their clients about the *NSW Charter of Victims' Rights*, and refer them to the Department of Justice's Victims Services Charter of Victims' Rights complaints process if they have complaints about the health services they have received which have not been resolved.

10.4 Human resources

10.4.1 Safety and security

It is the responsibility of the Local Health District and CPCS manager/clinical lead to ensure the safety and security of both staff and clients in accordance with the NSW Health Policy Directive *Work Health and Safety: Better Practice Procedures.* CPCS will:

- Identify and manage risks to secure and protect the health, safety and wellbeing of all members of staff, clients and stakeholders.
- Have a comprehensive work/health/safety framework in place to minimise risks to health, wellbeing and safety and to manage incidents promptly.
- Ensure that initial contact with clients is conducted in the premises of a designated office or patient treatment area or other safe environment and any outreach is provided in accordance with the guidance in Section 5.3.3.
- Install duress alarms where possible.
- Have protocols in place to manage risk for CPCS staff travelling out of the office, which include procedures to inform other staff of proposed visits and expected times of return.

CPCS staff should not wear Local Health District uniforms due to risks and disadvantages, including work, health and safety, and privacy reasons.

CPCS will implement the *Protecting People and Property — NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies*, which outlines a range of things including minimum standards for health care facilities, home visits, after-hours visits, emergency procedures and car breakdowns.

Protecting personal details

- CPCS staff will exercise care in protecting the personal details of all clients and staff members.
- Contact details and home addresses of CPCS staff will be kept in a secure location and not provided to any individual or agency without the express permission of the relevant staff member.

- All CPCS staff will ensure their personal belongings or identifying information are kept secure at all times. This includes passwords for computers and not leaving valuables or confidential information unsecured.
- Any circumstance where the personal information of CPCS staff has been or may have been obtained by any individual will be immediately reported to the staff member and the CPCS manager or clinical lead.
- Any circumstance where personal details of a client have been or may have been obtained by any individual will be reported immediately to the CPCS manager or clinical lead.

10.4.2 Ethical behaviour

CPCS is committed to ethical and accountable practice. The work of CPCS involves:

- Direct services to clients and communities.
- The possession of sensitive material.
- A position of power and authority over clients.

Accordingly, CPCS staff should refer to the relevant NSW Health policies, particularly:

- *NSW Health Code of Conduct*.
- *Conflict of Interest and Gifts and Benefits*.
- *Communications — Use & Management of Misuse of NSW Health Communications Systems*.

CPCS staff should also be aware of any further requirements for personal and professional behaviour of the Local Health District as well as their relevant professional bodies such as Australian Psychological Society, Australian Association of Social Workers, and Australian Health Practitioner Regulation Authority.

If any staff member encounters a situation that is not thoroughly clarified by the relevant policies, they should consult with their CPCS manager or clinical lead at the first opportunity. Specific circumstances of particular relevance to CPCS workers are also identified below.

Relationships with clients

CPCS staff will:

- Adhere to ethical personal and professional behaviour at all times and will not exploit their clients in any way.
- Not conduct sexual relationships or have sexual contact with clients, former clients or clients' immediate family members and/or carers.

Staff who have a pre-existing social or professional relationship with a client referred to the service will inform the CPCS manager or clinical lead of the relationships and complete a risk assessment. Where indicated, an alternative worker must be found.

Where there is a sole CPCS worker in a particular area, the Local Health District is responsible for ensuring that the client receives the service from an alternative counsellor.

Where an alternate counsellor is not available, service managers must have systems in place to ensure that professional boundaries are maintained.

Where pre-existing social or professional relationships exist due to the small size of the community, CPCS managers and clinical leads must have systems in place to ensure that professional boundaries are maintained.

Boundary violations in a therapeutic relationship may include:

- Going substantially over agreed length of time in sessions.
- Holding meetings outside appropriate office times or venues.
- Volunteering inappropriate personal information.
- Benefitting economically from a relationship.
- Social contact, and contact on social media.
- Sexualised behaviour.

It is the responsibility of CPCS staff to address boundary issues as they arise and to discuss them with their CPCS manager or clinical lead.

Regular supervision, consultation and professional development are essential for the prevention of boundary violations and maintenance of ethical standards (see also Section 10.4.5).

Giving or receiving gifts

CPCS staff will not give gifts to clients of the service. An exception may be token gifts to participants in group work or minimal cost gifts and cards given following clinical discussion (i.e. special and planned purpose, linked to counselling).

From time to time clients may give gifts to staff. Those gifts may be accepted provided they are not of a substantial value and no perception or suggestion of privilege is associated between giver and receiver.

All CPCS staff must comply with the Conflict of Interest and Gifts and Benefits policy.

10.4.3 Appropriate professional qualifications for CPCS staff

CPCS will maintain an appropriately qualified workforce to ensure a high quality of service delivery and to align with best practice.

All CPCS counsellors should have appropriate tertiary qualifications in the behavioural sciences, such as social work, psychology or tertiary (bachelor's degree or higher) level counselling.

Aboriginal counsellors who do not hold tertiary qualifications may be recruited on the basis of cultural expertise and will be supported to undertake training towards the required tertiary qualifications.

The CPCS manager or clinical lead will have the tertiary qualifications identified above as well as clinical experience in child protection and management skills.

Where the CPCS is located in rural and remote areas and recruitment for the people with the tertiary qualifications in the behaviour sciences as identified above is unsuccessful, qualifications in mental health can be considered. Local Health Districts considering this option can consult with NSW Health with regard to the additional training and supervision that will be required. Where CPCS are located in areas with high numbers of people from culturally and linguistically diverse backgrounds or Aboriginal communities, workers from these backgrounds will be encouraged to apply for positions.

10.4.4 Learning pathways for CPCS workers

Key elements of the learning pathways for CPCS counsellors include orientation, mandatory and recommended training, and ongoing professional development.

Orientation

Each CPCS will provide structured orientation program that all staff are required to complete which will cover agency policy and protocols, relevant work health and safety issues, expectation of workers, the agency profile and partnerships with key stakeholders. This will vary across Local Health Districts. It is important that new workers understand the work environment before attending core training and delivering services.

Core and strongly recommended training

Local Health Districts need to ensure that all CPCS managers, clinical leads and counsellors have access to the necessary resources (including assessment instruments and necessary training) to administer the core set of mandatory standardised outcome measures utilised in the CPCS assessment processes (see Section 6.1.2).

Core training for CPCS staff is delivered by the NSW Health Education Centre Against Violence (ECAV). This supports trauma-informed, collaborative and integrated responses to children, young people and families with a focus on application of a socio-political and violence, abuse and neglect clinical practice framework when addressing the impact of the range of violence, abuse and neglect issues involving children. Staff should attend the first available courses after commencing at the CPCS for core training below:

Table 4 Core training

Who	Training program
CPCS counsellors, managers and clinical leads	IN 1021 Integrated responses to interpersonal violence, abuse and neglect (Part 1) and IN 1022 Part 2 Integrated Child protection counselling (CPC) work
	IN 1018 Developing culturally safe trauma informed practice in Aboriginal communities
	DV-601 Practical Skills in Responding to People Who Have Experienced Domestic Violence
	CE-208 Working towards Cultural Competence

Additional ECAV training is strongly recommended for CPCS counsellors, managers and clinical leads as outlined in the table below.

Table 5 Strongly recommended training

Who	Training Program
CPCS counsellors, managers and clinical leads	IN-1006 Developing Skills in Report Writing and Giving Evidence
	SA-1211 Working with sexual assault: A course for NSW Health CPCS workers
	MB706 Skills for Working with Male Violence
	DV-611 Advanced workshop for domestic violence counselling
	SA 1226 Working with families around sexualised behaviours of their children (aged under 10)
	SA-1212 Foundations for working with adults sexually assaulted as children
	SA-1219 Working therapeutically with children & young people who have experienced sibling sexual assault
	DV-607 Domestic Violence and child protection: Developing good practice responses to a complex problem

Each Local Health District may identify additional training as mandatory or strongly recommended for CPCS staff.

Professional development

CPCS counsellors should have the opportunity for ongoing professional development to assist their practice around emerging clinical issues. The workplace needs to support the integration of new knowledge and skills gained from training and professional development.

Specifically, CPCS will:

- Allocate resources for the professional development and training of staff to assist in maintaining a knowledgeable and qualified workforce.

- Provide or support opportunities for CPCS staff to access ongoing professional development, including attendance at conferences, workshops and participation in formal education programs.
- Ensure that CPCS staff are provided with appropriate training to assist them in their roles.

The Local Health District will:

- Ensure that CPCS staff attend continuing professional development and education to ensure clients' access to quality, skilled, competent, and non-judgmental services.
- Encourage the ongoing development of management skills for CPCS managers and clinical leads. This may include training in the areas of supervision, planning, service management, staff selection, information management and media contact.
- Consult the NSW Health *Managing for Performance* Policy Directive which identifies the key features to be reflected in all NSW Health organisations' policies on performance management, including requirements for managing unsatisfactory performance.

10.4.5 Supervision and support

Supervision is important to underpin effective practice, to meet the needs of clients and for building and retaining a strong workforce.

> A key strategy for maintaining ethical practice and monitoring the quality, safety and wellbeing of staff is to provide external professional supervision, ensuring opportunities for counselling, debriefing, assistance, mentoring and clinical development (Australian Royal Commission into Institutional Responses to Child Sexual Abuse, 2017c, p. 145)

Further, a culture of supervision and staff support is an essential component of workforce health and safety, and in particular it is vital for staff retention, staff support and wellbeing, to prevent burnout, and to mitigate the effects of vicarious trauma (Australian Royal Commission into Institutional Responses to Child Sexual Abuse, 2017c).

This section discusses what is necessary to support and build clinical capacity, identifies some of the safety and risk issues for CPCS staff, and outlines the role and nature of supervision and other supports that enable the work to occur with intentional best practice. As with other parts of this Policy Directive, this section should be read in the context of broader NSW Health policy and other guidelines such as the Health Education and Training Institute's (HETI) *Superguide: A handbook for supervising allied health professionals* and the *NSW Health Clinical Supervision Framework*.

Potential impact of the work on staff

An important aspect of clinical capability is understanding the context in which the CPCS counsellor operates. CPCS counsellors are working with children, young people and families where issues of trauma associated with violence, abuse and neglect are the

norm. This is emotionally challenging and often requires critical decisions to be made under pressure. The presenting problems are complex and usually multifaceted.

It is now well recognised that practitioners can experience trauma as a result of engaging empathically with traumatised clients and bearing witness to the traumatic events in their lives. Research in child protection, social work, youth work and youth justice, all fields that have similarities to CPCS, has demonstrated that there are certain conditions that cause adverse impact for clinicians including:

- Work stress; excessive pressures or demands.
- Burnout: feeling emotional exhaustion and reduced accomplishment.
- Trauma: direct experiences of a threatening event that overwhelms coping ability.
- Vicarious trauma (VT): when someone is impacted from their exposure to trauma content (Russ, Lonne, & Darlington, 2009).

Studies have found high rates of VT (30-50%) in workers in child protection and related fields (Bell, 2003; Conrad & Kellar-Guenther, 2006; Cornille & Meyers, 1999). However, that means that 50-70% of these workers do NOT suffer those ill effects (Russ et al., 2009). It was found that: most child protection workers continue to operate effectively and to be satisfied in their jobs; some workers demonstrate and/or develop resilience in the face of this adversity (Russ et al., 2009), and many experience ‘compassion satisfaction’ (Figley, 1995).

Further, as also noted in Section 7.1, in addition to the high prevalence of violence, abuse and neglect in the general population (see Section 2 and Appendix 1), there are many professionals, and in particular health workers, with their own histories of violence, abuse and neglect (McLindon et al., 2018). These personal experiences of violence, abuse and neglect may also intersect with the professional practice of CPCS counsellors and their experiences of the impacts of the work, including VT.

Factors that have been found to be highly significant in protecting practitioners from the effects of burnout and VT include:

- ensuring appropriate and diverse caseloads;
- providing effective and regular supervision;
- encouraging a culture of debriefing and providing appropriate forums for this debriefing;
- staff and peer support and ongoing professional development;
- encouraging critically reflective practice and critical reflection (see Appendix 9); and
- building a workplace culture that negates the risks and experiences of vicarious trauma, embracing approaches to trauma-informed systems of care.

When workers experience trauma and chronic stress, they can also experience a physiological response as the brain’s threat response is activated, such as through

persistent fight, flight or freeze mechanisms. This physiological process narrows awareness and inhibits important functions of the brain which are fundamental to analytical thinking and self-management. As a consequence, reflective thought is often inhibited. When the threat response is activated it is more difficult to learn or make thoughtful decisions and to be self-regulated both emotionally and physically (Siegel & Solomon, 2003). Providing a context where practitioners can self-regulate to reduce or avoid the threat response is therefore critical to ensuring effective practice and supporting the wellbeing of the workforce.

Organisations have statutory and ethical requirements to protect workers under Workplace Health and Safety legislation. However, some work is inherently stressful, and characteristics of the work environment can add to or alleviate stress and trauma. Effective supervision, reflective processes and a culture of support are essential contributors to a safe work place.

Functions of supervision

Supervision is a relationship-based activity which can enable clinicians to reflect upon their work. “It provides a supportive, administrative and development context within which responsiveness to clients and accountable decision-making can be sustained” (Davies, 2000, cited in Health Education and Training Institute [HETI], 2012, p. 6). It also provides an opportunity for critical reflection (see Appendix 9).

Supervision needs to meet a number of functions such as:

- **Educational:** Meeting the developmental needs of the CPCS counsellor by providing knowledge and skills, developing capacity for self-reflection and self–awareness and integration of theory and practice. This can include identifying learning needs and supporting access to training within the scope of their practice.
- **Support:** Ensuring the CPCS counsellor is supported in managing the stresses of the work, developing a professional identity and sustaining morale.
- **Administrative:** Providing accountability, role clarity, management of workloads and addressing organisational issues (HETI, 2012).

Failure to ensure access to quality supervision and reflective processes can have detrimental effects for clients, practitioners and the health service, as has been demonstrated by numerous inquiries in Australia and overseas (Frederico, Jackson, & Dwyer, 2014; HETI, 2012; Eileen Munro, 2008). Consequences of inadequate supervision can include:

- problems in risk-assessment and case-planning
- lack of clarity in roles, goals and outcomes;
- interagency conflicts;
- difficulties managing priorities, waiting lists, and case closure; and
- worker stress, vicarious trauma and staff turnover.

Provision of supervision

The *NSW Health Clinical Supervision Framework* lists five core principles for clinical supervision:

- **Principle 1:** Clinical supervision is available to all health professionals to optimise client care and outcomes.
- **Principle 2:** Clinical supervision supports best practice and consistent delivery of client care.
- **Principle 3**: Clinical supervision is high quality and effective in addressing the needs of health professionals.
- **Principle 4**: Clinical supervision contributes to continuous professional learning and practice improvement.
- **Principle 5:** Clinical supervision supports high quality care through data collection and monitoring for continuous improvement.

These principles highlight the role of CPCS and the broader Local Health District in ensuring access to appropriate clinical supervision. The Framework recognises the range of ways clinical supervision needs may be met. Consistent with the Framework, CPCS will provide regular individual supervision and debriefing for their staff.

The manager or clinical lead of the CPCS:

- Must be qualified to provide case management and line management supervision to their staff.
- Will provide clinical supervision to staff where it is not possible to contract a supervisor who is either outside of the CPCS counsellor's line management or external to the Local Health District/NSW Health, or where a CPCS counsellor chooses this option.
- Will be supervised by a line manager.
- Will ensure sole CPCS counsellors have access to appropriate supervision.

Local Health Districts are responsible for ensuring supervision of CPCS managers and clinical leads who carry a clinical load.

In general, supervision for CPCS counsellors will be provided as follows:

- The content and style of supervision will be negotiated on an individual basis, taking account of the support, professional development, accountability and client needs. The outcome of these considerations will be formalised in a supervision agreement which will:
    - Be negotiated between the parties: CPCS manager/clinical lead, supervisor, and counsellor.
    - Ensure clarity of expectation about frequency, purpose and scope of clinical supervision, roles, fees, responsibilities, confidentiality, ethics and recording requirements.

  - Include learning and development goals for the practitioner.
  - Include a process of review and evaluation of the supervision on a regular basis (no less than 12-monthly), such as in conjunction with the annual professional development review (PDR) process to help ensure supervision remains accountable.

- Will be provided at regular intervals, the frequency and duration of which, will be determined by need (variously defined) and according to their awards where this applies. As a general principle, supervision occurs no less frequently than monthly, at an agreed regular time and at an agreed location.
- May include individual supervision, group supervision and supervision by telephone or telehealth.
- Will focus on review of counselling interventions, quality assurance, mentoring, developing clinical skills and reflection and debriefing and assistance in the management of vicarious trauma.
- Requires 'limited confidentiality', in that the specific content remains confidential between the supervisor and supervisee, unless there are ethical or quality concerns about the practitioner or their practice.
- Clients of the service need to be aware that the practitioner receives supervision and that their confidentiality is assured within the supervisory process.

Cross-cultural safety and support will also be provided for Aboriginal and non-Aboriginal staff. Cultural supervision with an appropriate Aboriginal consultant is particularly important for Aboriginal counsellors, as well as non-Aboriginal counsellors who have a high load of Aboriginal clients. It should also be undertaken by the whole CPCS team at regular intervals through the year (see also Section 8).

Useful supervision resources are available on the HETI website (www.heti.nsw.gov.au), and in particular in the *NSW Health Clinical Supervision Framework*. These include templates for supervision agreements and other documentation.

Accessing supervision in diverse settings

A line manager may perform clinical supervision functions if suitably qualified to do so; however, these functions could also be undertaken by another suitably qualified supervisor (HETI, 2015). This may include another employee within that Local Health District, another NSW Health employee, or an external clinical supervisor contracted to NSW Health for this purpose.

Given the specialist nature of the work undertaken by CPCS and the location and capacity of some Local Health District sites, the required clinical supervision may not always be available within existing line management structures. This is particularly a challenge for rural and remote workers (HETI, 2012) and due to the use of multidisciplinary teams within health care, meaning supervisors may not always be of the same discipline. CPCS counsellors, managers and/or clinical leads may also prefer separate line management and clinical supervision.

In the context of CPCS, managers and clinical leads need to have the necessary skills to enable them to meet the core functions of supervision and ensure staff have access to appropriate, quality supervision as identified above. The Local Health District has the responsibility to ensure these skills are made available if they are not accessible or not appropriate to be provided from within CPCS. This can be done through contracting an external provider for individual or group supervision, or making available another suitably qualified professional from within the Local Health District.

Where an external consultant is contracted to provide clinical supervision, they will always be responsible to the CPCS manager or clinical lead for their work within the service. They will also provide consultation consistent with the policies and procedures of the CPCS and of NSW Health, with particular attention to:

- *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*.
- *NSW Health Code of Conduct*
- *Managing Misconduct*.
- *Child Related Allegations, Charges and Convictions against NSW Health Staff*.
- *NSW Health Policy on Managing Complaints and Concerns about Clinicians*.

10.4.6 Performance appraisal/Professional development review

CPCS are committed to the provision of meaningful and beneficial performance appraisal aimed at promoting the accountability and professional development of all staff. Formal performance appraisal or professional development review will be undertaken according to Local Health District and Ministry of Health requirements.

Performance appraisal is a structured and interactive process and includes comprehensive reflection, consideration, discussion and feedback.

In the first year of service for CPCS counsellors, performance appraisal will take place not less than six-monthly. In subsequent years it will take place not less than yearly.

10.4.7 Student placement

CPCS will contribute to the education of tertiary students to increase their awareness and understanding of issues in relation to work concerning violence, abuse and neglect involving children.

Due to the sensitive nature of the work, a thorough assessment of the appropriateness of the student is essential for the protection of the student and clients of the service. CPCS will adhere to the requirements in *Clinical Placements in NSW Health Policy* and *Guidelines for Clinical Placements in NSW Health* in relation to student placements and have written guidelines regarding student placements. These guidelines will include:

- Supervisory arrangements.
- Feedback mechanisms.
- Confidentiality requirements.
- Development of a contract which outlines the role of the student while on placement.

Glossary and abbreviations

Glossary and acronyms/term	Description
Aboriginal English	Many Aboriginal people speak a form of Australian Aboriginal English some of the time and it is the first (and only) language of a large number of Aboriginal children (Butcher, 2008).
ACPP	Aboriginal Child Placement Principle.
AIHW	Australian Institute of Health and Welfare.
CAMHS	Child and Adolescent Mental Health Service (NSW Health). Further information is at Appendix 1.
Casework	Casework is a collaborative process of assessment, planning, facilitation, clinical intervention and advocacy for options and services to meet an individual's psychosocial and emotional needs through communication and available resources to promote quality cost-effective outcomes. While case work involves a range of activities to support a client in having their needs met, it does not require the level of coordination and responsibility by an individual worker that case management requires (see below).
Case plan	The case plan is a written document that identifies the goals, interventions, and outcomes for the child/young person and family/carers. Case planning is a process of planning strategies to address a child/young person's safety and care needs to promote a child/young person's wellbeing.
Case management	Case management co-ordinates individual client care and aims to improve service access and provision. It aims to strengthen outcomes for families, children and young people through integrated and co-ordinated service delivery between services and interagency partners to their clients.
Carer	Carers include a range of people who play a role in supporting children and young people in families. Carers can be unpaid, as defined by the *NSW Carers Recognition Act 2010*, such as those caring for a child or young person with a disability or illness, or a child/young person due to other family members not being able to. Carers also include those working in paid roles that provide support and care to children and young people.
Chapter 16A	Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* contains mechanisms for sharing information to another prescribed body that relates to the safety, welfare or wellbeing of a particular unborn child, child, young person or 'class of children' or young persons.

Glossary and acronyms/term	Description
Child and young person	In accordance with the *Children and Young Persons (Care and Protection) Act 1998*, a 'child' for the purpose of this Policy Directive is someone under 16 years old (0-15 years) and a 'young person' is someone who is 16 or 17 years old. Occasionally in this Policy Directive, particularly when quoting the literature, 'child' may refer to someone under the age of 18 years old; however, wherever specific policy advice or direction is given, the definition above applies.
Class of children /young people	A 'class of children/young people' is a group of children/young people having in common one attribute (e.g. attend the same institution) or a number of similar attributes. In the context of mandatory reporting under the *Children and Young Persons (Care and Protection) Act 1998*, a class of children report should be considered when there is sufficient reason to believe a group of children/young people is currently at risk of significant harm.
Client	For the purpose of these Policy Directives, a 'client' is some who has been referred to the CPCS, meets the service criteria (see Section 5.1.3) and for whom the referral has been accepted by the CPCS (Section 5.2.3).
Client advocacy	Client advocacy refers to activities to help meet the specific needs of an individual client or family and in particular refers to assisting them to navigate service systems, including negotiation of the complex web of interagency services. It is based on the premise of empowerment and responding to the expressed needs and wishes of the client and aims to enable individuals to exert a greater influence or control over their lives.
Clinical need assessment	A process of gathering information systematically about the client's psychosocial, health, clinical care and any other needs of a client which enables the clinician to develop a treatment or intervention plan. The assessment may be based on a variety of assessment approaches including clinical interview and assessment tools.
CPCS	Child Protection Counselling Service.
CPCS counsellor	A person employed by a NSW Health Child Protection Counselling Service
CPCS staff	A person employed by a NSW Health Child Protection Counselling Service (CPCS) in any capacity. This may include, but is not limited to a counsellor, manager, clinical lead, administration officer, Aboriginal Health worker

Glossary and acronyms/term	Description
CPU/CPT	Child Protection Unit/Child Protection Team. Further information is at Appendix 2.
Crisis	Crisis refers to a time of intense difficulty or danger for a client. This danger may be external to the client (e.g. acute risk from a perpetrator of violence) or internal to the client (e.g. acute suicidality).
CSC	Community Services Centre — local Family and Community Services (FACS) office.
Child Protection Helpline	The Child Protection Helpline is a 24-hour statewide service for anyone to contact Family and Community Services (FACS) about the care and protection of children and young people.
Cultural competence	Cultural competence is the ability to identify and challenge one's own cultural assumptions, values and beliefs so as to demonstrate respect and minimise adverse effects on communication with any client. It is about developing empathy and appreciating that there are many different ways of viewing the world, influenced by culture. It is a term that is particularly, although not exclusively, used in the context of working with Aboriginal people and communities.
Culture	'Culture' refers to the language, beliefs and practices different groups of people use to articulate their identity, often in relation to specific traditions of ethnicity, race, religion, spirituality, occupation, stage of life, social relations and sexual identity.
CWUs	Child Wellbeing Units. CWUs operate in the following four government agencies: • NSW Police Force. • Department of Education and Communities. • NSW Health. CWUs help agency staff to collaborate in assessing the level of risk, detecting patterns of neglect and/or cumulative harm, intervening early before matters escalate, and building a case for statutory intervention when early intervention and prevention are no longer a safe option for a child or young person. Further information is at Appendix 2.
Care Act	*Children and Young Persons (Care and Protection) Act 1998.*
DASS	Depression Anxiety Stress Scales (Lovibond & Lovibond, 1995). The DASS is a 42-item self-report instrument to measure the emotional states of depression, anxiety and

Glossary and acronyms/term	Description
	tension/stress. It can be used with adolescents and adults.
ECAV	Education Centre Against Violence.
FACS	Family and Community Services, NSW Government department with statutory child protection responsibilities.
Health service, Health facility	Any public health organisation as defined under the *Health Services Act 1997*, the Ambulance Service of NSW, Health Infrastructure, HealthShare NSW, NSW Health Pathology, any other administrative unit of the Health Administration Corporation, and Albury-Wodonga Health in respect of staff who are employed in the NSW Health Service. This includes the range of violence, abuse and neglect services including integrated violence services such as Violence, Abuse and Neglect (VAN) or Integrated Violence Prevention and Response Service (IVPRS) (see also services detailed at Appendix 2).
Health (or NSW Health) worker/staff	Includes anyone working in NSW Health, whether as a paid staff member or engaged in any other capacity, including as a volunteer, visiting practitioner, student attending clinical placement or anyone else appointed on an honorary or contractual basis.
HETI	Health Education and Training Institute.
HoNOS/CA	Health of the Nation Outcomes Scale (HoNOS) and Health of the Nation Outcomes Scale for Children and Adolescents (HoNOSCA). HoNOSCA was developed for children and adolescents (under the age of 18) in contact with mental health services (Gowers, Bailey-Rogers, Shore, & Levine, 2000).
Institutional abuse	Institutional abuse is the mistreatment or neglect of a child, young person or adult by a regime, or individuals within settings and services, in which that child, young person or adult lives or uses. Such abuse violates the person's dignity, resulting in lack of respect for their human rights.
Joint Child Protection Response Program	Joint Child Protection Response Program (the Program). Further information is at Appendix 2.
Local Health Districts (LHD) and Speciality Health Networks (SHN)	NSW Health has eight Local Health Districts (LHDs) in the Sydney metropolitan region, and seven in rural and regional NSW. In addition, there are two specialist health networks which focus on children's and paediatric services, and Justice Health and Forensic Mental Health.
Mandatory reporter	A person who as part of their work delivers health care,

Glossary and acronyms/term	Description
	welfare, education, children's services, residential services or law enforcement to children or young people. Mandatory reporters are required under Section 27 of the *Children and Young Persons (Care and Protection) Act 1998* to make a report to the Child Protection Helpline if they suspect or have information that a child is at risk of significant harm as detailed under Section 23 of the Act.
My Health Record	My Health Record is a secure online summary of an individual's health information. Healthcare providers authorised by their healthcare organisation can access My Health Record to view and add to their patients' health information. Information available through My Health Record can include, a patient's health summary, medication prescribing and dispensing history, pathology reports, diagnostic imaging reports and discharge summaries.
New Street	New Street Services provides specialist services to young people (10-17 years old) who have engaged in sexually harmful behaviours towards others. Further information is at Appendix 2.
NCFAS	North Carolina Family Assessment Scale (Kirk, 2012) — measures family functioning from the clinician's perspective.
ODPP	Office of the Director of Public Prosecutions.
OOHC (Out-of-home care)	Out-of-home care is one of a range of services provided to children who are in need of care and protection (and their families). This type of service assists and supports children and young people in a variety of care arrangements other than with their parents. These arrangements include foster care, placements with relatives or kin, and residential care. In most Australian jurisdictions, children will be placed in out-of-home care in conjunction with being placed on a care and protection order.
Parent/carer	An adult who attends to and has responsibility for the needs of a child or young person or a dependent adult either as 'person responsible', as a guardian or has parental responsibility under the *Children and Young Persons (Care and Protection) Act 1998*.
Prescribed body	Chapter 16A provides a scheme for information-sharing among human services and justice agencies and NGOs 'prescribed bodies'. A '**prescribed body**' means: a) the NSW Police Force, a Public Service agency or a public authority, or (b) a government school or a registered non-government

Glossary and acronyms/term	Description
	school within the meaning of the *Education Act 1990*, or (c) a TAFE establishment within the meaning of the *Technical and Further Education Commission Act 1990*, or (d) a public health organisation within the meaning of the *Health Services Act 1997*, or (e) a private health facility within the meaning of the *Private Health Facilities Act 2007*, as per the *Children and Young Persons (Care and Protection) Act 1998*, or (f) any other body or class of bodies (including an unincorporated body or bodies) prescribed in clause 8 of the *Children and Young Persons (Care and Protection) Regulation 2012* Thus includes NSW: (a) enrolled nurses and registered nurses, (b) medical practitioners, (c) midwives, (d) psychologists, (e) occupational therapists, (f) speech pathologists eligible for membership of Speech Pathology Australia.
Psychosocial assessment	A psychosocial assessment is an evaluation of a client's mental, physical, social, physiological and emotional health. It takes into account all aspects of the client's life including the client's perception of self and his or her ability to function in the community.
Risk of Significant Harm (ROSH)	Under Section 23 of the *Children and Young Persons (Care and Protection) Act 1998* 'risk of significant harm' (or ROSH) refers to where current concerns exist for the safety, welfare or wellbeing of the child or young person because of the presence, to a significant extent, of any one or more of the following circumstances: (a) the child's or young person's basic physical or psychological needs are not being met or are at risk of not being met, (b) the parents or other caregivers have not arranged and are unable or unwilling to arrange for the child or young person to receive necessary medical care, (b1) in the case of a child or young person who is required to attend school in accordance with the Education Act 1990 — the parents or other caregivers have not arranged and are unable or unwilling to arrange for the child or young person to receive an education in accordance with that Act, (c) the child or young person has been, or is at risk of being,

Glossary and acronyms/term	Description
	physically or sexually abused or ill-treated, (d) the child or young person is living in a household where there have been incidents of domestic violence and, as a consequence, the child or young person is at risk of serious physical or psychological harm, (e) a parent or other caregiver has behaved in such a way towards the child or young person that the child or young person has suffered or is at risk of suffering serious psychological harm, (f) the child was the subject of a pre-natal report under section 25 and the birth mother of the child did not engage successfully with support services to eliminate, or minimise to the lowest level reasonably practical, the risk factors that gave rise to the report. The Child Protection Helpline determines Risk of Significant Harm based in the information reported as well as whether the information requires a new statutory response.
SARA	Safety and Risk Assessment as part of the Structured Decision-making model for Family and Community Services (FACS).
SAS	Sexual Assault Service.
SDM®	Structured Decision Making system.
SDQ	Strengths and Difficulties Questionnaire: A standardised measure on emotional and behavioural strengths and difficulties that can be completed by young people, carers or parents and teachers (Goodman, 1999).
Secondary consultation	Secondary consultation involves providing advice regarding a child/young person and/or family/carers in response to questions or concerns by others, but does not involve direct contact with the child. Care responsibility remains with the worker/organisation seeking consultation.
Substantiation	Substantiation refers to where FACS has conducted an investigation and concluded there is reasonable cause to believe that the child had been, was being, or was likely to be, abused, neglected or otherwise harmed (AIFS, 2017)
Suspected ROSH report	A report made to the Child Protection Helpline about a child or young person who the reporter suspects may be at risk of significant harm due to the circumstances outlined in Sections 23 (see ‘risk of significant harm’ above) or in Sections 120, 121 and 122 (all concerning homelessness) of

Glossary and acronyms/term	Description
	the *Children and Young Persons (Care and Protection) Act 1998*
Systems advocacy	Systems advocacy seeks to influence and change systems as a whole. It is a 'political process by an individual or group which aims to influence policy and resource allocation within political, economic and social systems and institutions' (National Association of Services Against Sexual Violence, 2015, p. 18). This may include through advocacy for legislation, policy or practice change to positively impact on the people who have experienced violence, abuse and neglect as a whole, rather than individual clients.
Trauma-informed service	'A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization' (Substance Abuse and Mental Health Services Administration, 2014, p. 9).
Trauma-specific service	A trauma-specific service is one that is aware of the possibility of ongoing or re-traumatisation of clients and of the direct and indirect impacts on its staff and takes steps to reduce this wherever possible. A trauma-specific service recognises there are many potential pathways to recovery and to building resilience in clients. A trauma-specific service provides therapeutic approaches with the aim to help a person manage and reduce trauma-related symptoms and integrate their experiences of trauma so these no longer intrude on the present (Bateman, Henderson, & Kezelman, 2013; Fallot & Harris, 2006; Substance Abuse and Mental Health Services Administration, 2014).
Victims Services (VS)	Victims Services is part of the NSW Department of Attorney General and Justice. It provides support, information, referrals, counselling and compensation services to victims of violent crimes and witnesses to violent crimes. It also provides compensation and counselling services to relatives of someone who has died as a result of a violent crime.
Vicarious trauma	'Vicarious trauma is described as a transformation in a worker as a result of working with a person who has been traumatised. Vicarious trauma is a cumulative effect of working with trauma which can affect many aspects of a

Glossary and acronyms/term	Description
	person's life. It may consist of short-term, or longer term effects that continue after the work has finished. Some effects of vicarious traumatisation parallel those experienced by the trauma survivor, and can lead to a person experiencing the symptoms of PTSD' (Bateman et al., 2013, p. 65).

Appendix 1: Overview of violence, abuse and neglect

Violence, abuse and neglect is recognised by the World Health Organization (World Health Organisation (WHO), 2014) as a serious public health and human rights issues with long-term personal, social, health and economic costs to individuals as well as to the broader community. The consequences of violence, abuse and neglect are wide-ranging, varied and include impacts on all aspects of an individual's life.

"Violence, abuse and neglect" (VAN) is used here as an umbrella term for three types of interpersonal violence that are widespread in the Australian community: sexual assault; all forms of child abuse and neglect; and domestic and family violence. While the dynamics in each sub-group can differ, there is a high degree of connection and overlap in the experience of, and responses to, these issues. There is also a substantial connection and overlap between violence, abuse and neglect and children and young people who use problematic or harmful sexual behaviour.

Understanding the issues and the evidence base

As described in Section 2, Framing the Issues, child abuse and neglect describes different types of maltreatment of a child. It includes physical abuse, neglect, sexual abuse, and emotional abuse or psychological harm, inappropriate treatment, exposure to behaviour that might cause psychological harm, including exposure to domestic and family violence, and assault including sexual assault (NSW Health, 2013, pp. 94-95). Various forms of child abuse and neglect can be a criminal offence under the Crimes Act (1900). Child abuse and neglect usually occurs within the context of adult-child/young person relationships where the child or young person trusts the adult and relies on them for basic needs.

Obtaining accurate Australian child maltreatment prevalence data is difficult (O'Donnell, Scott, & Stanley, 2008). National child protection statistics are one of the few sources to highlight the extent of child abuse and neglect. However, this data is limited in that it only collects information from cases referred to statutory Child Protection Services, rather than the actual incidence of abuse or neglect. Data from Justice agencies (e.g. Police and Courts) only captures those events that have been reported. Evidence suggests that a considerable amount of abuse and neglect goes undisclosed, making it difficult to develop an accurate picture (Hunter, 2014). Despite these limitations in relation to the type and usefulness of child protection data, the evidence we do have tells us that there is a significant number of children and young people living in NSW who are maltreated and subjected to abuse and neglect.

In 2016-17, 168,352 Australian children received an investigation, care and protection order, and/or were placed in out-of-home care (Australian Institute of Health and Welfare (AIHW), 2018a). One in 32 children received child protection services, with 74 per cent being repeat clients. Child protection data identifies Aboriginal and Torres Strait Islander children as being over-represented in the population of children who receive statutory child protection services, being 7 times as likely to receive such services when compared to non-Aboriginal and Torres Strait Islander children. Children from remote areas had the highest rates of substantiations, with children from very remote areas being four times as

likely as those from major cities to be the subject of a substantiation (Australian Institute of Health and Welfare (AIHW), 2018a).

There has been limited research into the various forms of child abuse, neglect and other childhood adversity in Australia that can be considered representative of the general population or provide reliable prevalence data (Mathews et al., 2016). However, a number of recent studies that have either measured one or two maltreatment types in detail, or have superficially measured all individual maltreatment types as part of a larger study have been examined (Rosier, 2017). Despite the difficulties involved in measuring the extent of child maltreatment in the wider population, it is very clear that it occurs at significant levels in the Australian context (Rosier, 2017). Child protection and crime statistics can offer data on reported child abuse and neglect. Some of these statistics are outlined below; however, the statistics often vary substantially due to definitions of child abuse and sources of statistics and/or research techniques used in different studies.

- A Child Family Community Australia Resource Sheet on the prevalence of child abuse and neglect (Price-Robertson, Bromfield, & Vassallo, 2010) identifies the prevalence rate for child abuse in the following categories:
    - neglect is 12%.
    - emotional abuse is 11%.
    - witnessing domestic and family violence is 12-23%.
    - penetrative sexual abuse for females is 7-12% and males is 4-8%.
    - non-penetrative sexual abuse for females is 23-36% and males is 12-16%.
- Other research identifies that it is widely recognised that neglect is the most common form of child maltreatment in the Western world. In this source the estimated prevalence of child neglect in Australia is 2.4 per cent overall (0.1-6.6%), and 2 per cent (0.6-4.1%) for males and 3.5 per cent (0-13%) for females. Research suggests that neglect is the second most common form of substantiated maltreatment in Australia, following emotional abuse. Some research suggests that the prevalence of child neglect is higher when children and young people are asked to report on their own experiences (NSW Family and Community Services, 2017a).
- Incidence of child abuse and neglect reported to the child protection system:
    - 379,459 notifications of suspected child abuse and neglect were made to state and territory authorities (a rate of 34.0 notifications per 1,000 Australian children) in 2016-17 (Australian Institute of Health and Welfare [AIHW], 2018a).
    - NSW recorded a total number of 18,919 substantiations of reports (children and young people in ROSH reports where a secondary assessment determined actual harm or risk of harm) in 2016-17 and 66,689 children were receiving child protection services.
    - 20,453 children were on care and protection orders and 17,879 children were living in out of home care (AIHW, 2018a).

- Nationally, between 2012-13 and 2016-17, the numbers of notifications, investigations, and substantiations all rose by:
    - 39% for notifications (from 272,980 to 379,459)
    - 45% for investigations (from 122,496 to 177,056)
    - 27% for substantiations (from 53,666 to 67,968) (AIHW, 2018a).

Types of abuse and neglect

The 'primary' type of abuse recorded in substantiations is the one considered most likely to place the child at risk, or be most severe in the short term. Nationally, emotional abuse was the most common primary type of abuse or neglect substantiated for children (48%), followed by neglect (24%), physical abuse (16%), and sexual abuse (12%) (AIHW, 2018a).

'Co-occurrence' is when other types of abuse or neglect are also recorded by child protection services as part of the substantiation. Emotional abuse and neglect were most likely to co-occur, with average co-occurrences of 30 per cent and 28 per cent, respectively. Emotional abuse co-occurred in just under half (45%) of all substantiations where physical abuse was the primary type of substantiated abuse or neglect, and in just under one-quarter (23%) of substantiations where sexual abuse was the primary type. Neglect co-occurred in 32 per cent of cases where emotional abuse was the primary type of substantiated abuse and in 25 per cent of substantiations where physical abuse was the primary type. The co-occurrence of sexual abuse was much lower than all other types of abuse or neglect, with an average co-occurrence of 2 per cent or less AIHW, 2018a).

The 2016 Personal Safety Survey (Australian Bureau of Statistics, 2017) collects information about women and men's experiences of abuse before the age of 15 years. Although not providing comprehensive data on all forms of violence, abuse and neglect involving children, this nevertheless provides valuable insights especially as it is a whole of population 'crime victimisation survey' that is the most comprehensive and robust quantitative survey of interpersonal violence in Australia (Cox, 2016, p. 2). It found:

- Approximately one in six women (16% or 1.5 million) and one in nine men (11% or 992,000) experienced physical and/or sexual abuse before the age of 15 (Australian Bureau of Statistics, 2017).[10]
- One in eight women (13% or 1.2 million) and one in ten men (10% or 896,700) witnessed violence towards their mother by a partner before the age of 15
- One in 20 women (4.7% or 440,900) and one in 25 men (4% or 380,000) witnessed violence towards their father by a partner before the age of 15.

Co-occurrence and links between forms of violence, abuse and neglect

Although practitioners and policy makers often talk about domestic and family violence, child abuse and neglect, and sexual assault as separate and quite distinct types of

[10] Noting that this is an under-representation of these issues as it does not include child emotional abuse and neglect.

violence, the evidence strongly suggests that these concepts are intrinsically linked and connected. It is difficult to separate and respond to one single issue on its own. The same applies to understanding and responding to victim-survivors and perpetrators of violence. At times victims may become perpetrators of violence and perpetrators may also be victims.

There are a number of terms used to describe these connections and the cumulative effect of experiencing a number of types of violence at different points in time. These include: accumulated trauma/exposures to violence; re-traumatisation; re-victimisation, co-occurrence, cumulative exposure/effects, or poly-victimisation. What is important is that one type of abuse rarely occurs in isolation of others; a single abusive experience is often the exception rather than the norm. The socio-ecological model of understanding violence, abuse and neglect also illustrates that the cause of the different forms of violence are also the same or inter-linked with each other. There are significant detrimental effects on a person's health for any one type of abuse (sexual, physical, or psychological/emotional abuse); however, health consequences may be incrementally worse for victims experiencing multiple types of abuse, either co-occurring, or compounding over a life time.

Neglect refers to a broad range of caregiver behaviours resulting in a child or young person experiencing deprivation. Most children experience neglect as repeated and persistent events as opposed to a single acute episode. Neglect has the most damaging impacts for a child or young person when it continues across developmental stages, with harm accumulating over time. (NSW Family and Community Services, 2017b).

Some examples of the overlaps between forms of violence, abuse and neglect to consider include:

- Different forms of violence experienced by women and their children at the hands of the same perpetrator: for example, domestic violence and child abuse. At least 50 per cent of men who are violent to their partners also abuse their children (Antle et al., 2007). Different experiences of violence by the same victim-survivor, for example a woman who experienced childhood sexual assault, then experienced adult sexual assault and domestic violence in her adult life. Women who experienced childhood sexual assault are 2.44 times more likely to experience psychological abuse by a partner in adulthood and 2.75 times more likely to experience physical abuse by a partner in adulthood (Cox, 2016).
- A child who has experienced sexual assault, domestic violence and chronic neglect who then displays problematic sexualized behaviours.
- Cumulative harm is particularly relevant to child neglect, due to the often chronic nature of neglect and its frequent co-occurrence with other forms of maltreatment (NSW Family and Community Services, 2017a).
- There is a correlation between neglect and domestic and family violence, whereby 'the more severe the violence the greater the lack of supervision and neglect of children in the family' (Laing & Humphreys, 2013).

The research and literature provides substantial evidence on the significant co-occurrence of forms of violence, abuse and neglect and their impact. For example:

- About one in three women who experience physical violence are also raped by violent partners (Campbell et al., 2003).
- Sexual abuse and domestic violence frequently co-exist. In one study 40-55 per cent of children who experienced sexual abuse were also exposed to domestic violence (Kellogg & Menard, 2003). Sexual abuse of children by men who perpetrate family and domestic violence is also likely to be under-reported as children are often too frightened to disclose (Harne 2011, cited in Department for Child Protection, 2013).
- A meta-analysis of 80 studies (12,252 survivors) found a mean prevalence of sexual revictimisation across studies was 47.9 per cent; that is, almost half of child sexual abuse survivors are also sexually victimised in the future (Walker, Freud, Ellis, Fraine, & Wilson, 2017).
- Children living with domestic violence are at increased risk of experiencing emotional, physical and sexual abuse, with the rate of co-occurrence of domestic violence and child abuse estimated at rates between 45-70 per cent (Holt, Buckley, & Whelan, 2008).
- More than half (56.8%) of children and young people aged 10-17 years surveyed who had witnessed domestic violence had also been maltreated (Hamby, Finkelhor, Turner, & Ormrod, 2010).
- 'Approximately 60 per cent of physical abuse occurs in homes where there is family and domestic violence (Moloney et al., 2007). This includes children who are harmed during an assault against the non-abusive adult victim (for example, when the child is being held or tries to intervene in the violence) and harmed intentionally as a means to punish the adult victim (scapegoating)' (Department for Child Protection, 2013, p. 24).
- The co-occurrence of domestic violence and child sexual abuse is under-studied, however rates of 12-70 per cent have been found, with higher rates found in clinical samples (Bidarra, Lessard, & Dumont, 2016).
- Between 35-50 per cent of children under 10 with problematic or harmful sexual behaviours have experienced sexual abuse and between 35-50 per cent have experienced physical or emotional abuse, neglect and/or have witnessed domestic violence (Evertsz et al., 2012).
- While experiencing sexual assault is associated with increased risk of young people sexually harming (Aebi et al., 2015), this is not the sole causal factor. Other contributing factors in the development of harmful behaviours include exposure to domestic violence; chronic, long-term neglect; and inappropriately witnessing sexual activity (Pratt, Miller, & Boyd, 2010).
- Girls with harmful sexual behaviours are more likely than boys to have a more severe history of victimisation (Thibaut et al., 2016).

Children and young people with problematic or harmful sexual behaviour

Problematic and harmful sexual behaviour refers to behaviour of a sexual nature outside the range accepted as 'normal' for a child's age and level of development, is detrimental to development and normal functioning, and may harm the child themselves, other children subjected to this behaviour, or place either child/children at risk of harm. These behaviours may include 'excessive self-stimulation, sexual approaches to adults, obsessive interests in pornography, and sexual overtures to other children that are excessive to developmental bounds. For some children, these [behaviours] are highly coercive and involve force; acts that would be described as "abusive" were it not for the child's age' (O'Brien, 2010, cited in Evertsz et al., 2012, p. 6).

A more recent definition is found in the *Now I know it was wrong* report of the parliamentary inquiry into support and sanctions for children who display harmful sexual behaviour.

> Harmful sexual behaviour is when children and young people (under 18) engage in sexual discussions or activities that are inappropriate for their age or stage of development, often with other individuals who they have power over by virtue of age, emotional maturity, gender, physical strength, or intellect and where the victim in this relationship has suffered a betrayal of trust. These activities can range from using sexually explicit words and phrases to full penetrative sex with other children or adults. (Barnardos, 2016, p. 10)

There is a strong link between problematic and harmful sexual behaviour and the child's own experience of sexual abuse or other forms of interpersonal violence. Vulnerability to developing problematic or harmful sexual behaviour arises from a complex interaction of factors related to the child, family and social environment (Gil & Shaw, 2013). While this means 'no single causal factor can best explain or predict sexual behaviour problems in children' (Gil & Shaw, 2013, p. 8), sexual abuse (including sexual contact and exposure to sexually explicit material) is recognised as a frequent precursor to it (Cashmore & Shackel, 2013; CEASE, 2012; Gil & Shaw, 2013; KPMG, 2014). In addition to sexual abuse, other factors associated with problematic sexual behaviour in children include: complex trauma histories including other forms of child maltreatment, domestic and family violence; problems in family functioning; poverty; loss; and family stress (Cashmore & Shackel, 2013; CEASE, 2012; Gil & Shaw, 2013; KPMG, 2014).

In efforts to understand this population, children under the age of 10 years of age are differentiated as a group from those aged over 10 years. This is related both to the age of criminal responsibility being 10 years old in Australian jurisdictions, and to developmental considerations. Terms such as 'reactive', 'problematic' or 'sexualised' behaviour are typically used to refer to children under 10, while the terms 'harmful sexual behaviours' and 'sexually abusive behaviours' are commonly used for children and young people aged over 10, reflecting recognition of different dynamics that require different approaches. In NSW, the term problematic or harmful sexual behaviour is used and services for children under 10 years old and their families/caregivers are provided through multiple NSW Health services; Sexual Assault Services, Child Protection Units, Child Protection Counselling Services, Child and Adolescent Mental Health Services, and

Community Health Child and Family Services. For children and young people between 10-17 years old who have harmful sexual behaviours and who, for a range of reasons, have not been criminally prosecuted, services are provided by New Street Services.

Some key messages about both of these populations groups from the literature include:

- Age appropriate and normal sexual behaviour needs to be distinguished from problematic, harmful or developmentally inappropriate behaviour (Kellogg, 2009).
- Children and young people who have demonstrated sexually harmful behaviours often have complex trauma histories including sexual assault in their histories (Cashmore & Shackel, 2013; CEASE, 2012; Gil & Shaw, 2013; KPMG, 2014).
- Between 35-50 per cent of children under 10 with problematic or harmful sexual behaviours have experienced sexual abuse and between 35-50 per cent have experienced physical or emotional abuse, neglect and/or have witnessed domestic violence (Evertsz et al., 2012).
- A high proportion of clients of New Street (young people aged 10 to 17 who have demonstrated sexually harmful behaviours) have complex trauma histories. Ten per cent of New Street clients are girls who have significant prevalence of complex trauma, including sexual assault in their histories (KPMG, 2014).
- Children with harmful sexual behaviours are predominantly male, older than their victim and known by the victim (Australian Royal Commission into Institutional Responses to Child Sexual Abuse, 2017d).
- Although, similarly to adult offenders, the majority of children and young people with harmful sexual behaviours are male, international studies find that between 2.6-12 per cent of children and young people with harmful sexual behaviours are female (Australian Royal Commission into Institutional Responses to Child Sexual Abuse, 2017d).

Domestic and family violence

The term ‘domestic violence’ usually refers to violence against an intimate partner or ex-partner, while ‘family violence’ may include violence perpetrated against children, older people, against parents by children, and other kin or family members. Many Aboriginal and Torres Strait Islander communities prefer the use of the term ‘family violence’ to reflect broader family and kin relationships involved in violence. Family violence is often connected to intimate partner violence, with women and children continuing to experience its most profound effects and women continuing to be most at risk of harm from their intimate partners (Toivonen & Backhouse, 2018).

While there is no single definition, the central element of domestic violence is an ongoing pattern of behaviour aimed at controlling a partner through fear, for example by using behaviour which is violent and threatening. In most cases, the violent behaviour is part of a range of tactics to exercise power and control over women and their children, and can be both criminal and non-criminal (Council of Australian Governments [COAG], 2011).

In NSW, the definition of domestic and family violence commonly used in Government is ‘any behaviour in a domestic relationship, which is violent, threatening, coercive or

controlling and causing a person to fear for their own or someone else's safety. It is usually manifested as part of a pattern of controlling or coercive behaviour' (NSW Department of Justice, 2014). The behaviours that may constitute domestic and family violence include (adapted from NSW Department of Justice 2014):

- physical violence including physical assault or abuse;
- sexual assault and other sexually abusive or coercive behavior;
- emotional or psychological abuse including verbal abuse and threats of violence;
- economic abuse, for example denying a person reasonable financial autonomy or financial support;
- stalking, for example harassment, intimidation or coercion of the other person's family in order to cause fear or ongoing harassment;
- kidnapping or deprivation of liberty, as well as unreasonably preventing the other person from making or keeping connections with her or his family or kin, friends, faith or culture;
- damage to property irrespective of whether the victim owns the property;
- spiritual violence: including but not limited to ridiculing or preventing victim survivors' practice of faith or culture and/or manipulating religious and spiritual teachings or cultural traditions to excuse the violence;
- technology-facilitated abuse: including but not limited to the use of text, email, phone to abuse, monitor, humiliate or punish, or threats such as to distribute private photos/videos of victim-survivors of a sexual nature; and
- causing injury or death to an animal irrespective of whether the victim owns the animal.

The *National Plan to Reduce Violence against Women and their Children 2010-2022* (COAG, 2011) identifies domestic and family violence and sexual assault as gendered crimes that have an unequal impact on women and are the most pervasive forms of violence experienced by women in Australia. While national and international evidence and data acknowledge a small proportion of men are victims of domestic and family violence and sexual assault, the majority of people who experience this kind of violence are women in their homes, at the hands of men they know.

New South Wales recognises that children's exposure to domestic and family violence constitutes maltreatment, even if they are not a direct victim of the violence. Exposure to domestic and family violence poses a risk to a child's physical, emotional and psychological safety. The harmful effects on the developmental and emotional wellbeing of exposure to domestic and family violence are clear and there is increasing attention on children as victim-survivors of family violence in their own right, with their own unique risks and service needs (Fitz-Gibbon et al., 2018; Laing et al., 2018).

The 2016 Australian Bureau of Statistics' (ABS) Personal Safety Survey (Australian Bureau of Statistics, 2017) found that in Australia:

- Women were nearly three times more likely to have experienced partner violence than men, with approximately one in six women (17% or 1.6 million) and one in sixteen men (6.1% or 547,600) having experienced partner violence since the age of 15.
- Since the age of 15,
    - One in four women (23% or 2.2 million) and one in 13 men (7.8% or 703,000) experienced violence by an intimate partner.
    - One in five women (19% or 1.8 million) and one in 14 men (7.1% or 654,200) experienced physical violence by an intimate partner.
    - One in 11 women (9.2% or 864,000) and one in 83 men (1.2% or 104,800) experienced sexual violence by an intimate partner.
    - One in four women (23% or 2.2 million) and one in six men (16% or 1.4 million) reported experiencing emotional abuse by a current and/or previous partner since the age of 15.
- One in 10 men witnessed violence towards their mother by a partner before the age of 15 (10% or 896,700) and one in 25 witnessed violence towards their father by a partner before the age of 15 (4% or 380,000)
- One in eight women witnessed violence towards their mother by a partner before the age of 15 (13% or 1.2 million) and one in 20 witnessed violence towards their father by a partner before the age of 15 (4.7% or 440,900).
- In the most recent physical assault by a male in the last 10 years, women were most likely to be physically assaulted by a male they knew (92% or 370,500) and the location of the incident was most likely to be in their home (65% or 689,800). Men were most likely to be physically assaulted by a male stranger (66% or 873,100) and the location of the incident was most likely to be either a place of entertainment or recreation venue (28% or 370,700) or outside location (28% or 370,500).
- Fifty per cent (60,300) of Australian women who were caring for children while experiencing violence from a current partner reported that their children either heard or saw the violence.
- Nearly half (48% or 325,900) of women who have experienced violence by a previous partner and who were pregnant during that relationship, experienced violence from their partner while pregnant. Humphreys (2007) highlights this violence as ‘double-intentioned’, where perpetrators may aim physical violence at their partner’s abdomen, genitals or breasts, so that abuse is both of the mother and child.

Other research also highlights:

- For eight in 20 hospitalisations for female assault victims (45% or 2,800) and for one in 20 hospitalisations for male assault victims, a spouse or domestic partner was the perpetrator (where the perpetrator was identified) (AIHW, 2018b).

- Four in five (79% or 99) victims of intimate partner homicide were female and one in five (21% or 27) victims of intimate partner homicide victims were male in the two years from mid-2012 to mid-2014(AIHW, 2018b).
- Intimate partner violence contributes more to the burden of disease (the impact of illness, disability and premature death) of adult women in their reproductive age (18-44 years) than any other risk factor. It contributes an estimated 5.1 per cent of the burden for women aged 18-44 years (Ayre, Lum On, Webster, Gourley, & Moon, 2016).

While male to female partner violence is by far the largest category of domestic and family violence, other patterns of violence can occur. Violence can occur in same sex relationships, to other family members such as the elderly or extended family and to people who are marginalised due to sexuality, race or disability. These types of violence may be harder to identify and victims may find it more difficult to access services.

There is also evidence that female-to-male violence does occur. However, the nature and consequences of women's violence is commonly different to men's violence towards women. When comparing male and female perpetrated violence, the violence women experience is more severe, more frequent and women are more likely to be seriously injured and to die at the hands of a male partner (Flood, 2006; Humphreys & Stanley, 2006; James, 1999; Kimmel, 2002; World Health Organisation (WHO), 2012). In addition, men are more likely to use violence *instrumentally* to dominate, control, injure, terrorise, and instil fear in their partner and this violence often escalates if their partner uses violence in self-defence or they experience some other loss of control of their partner such as separation. In this way, men's violence against their female partners reflects common definitions of domestic violence. In contrast, women are more likely to use violence *expressively* as a reflection of their dependence on their male partner and in response to frustration, stress or in self-defence (DeKeseredy & Schwartz, 1998; James, 1999; Muftić & Bouffard, 2007; Swan & Snow, 2002).

The research evidence is that there are underlying individual, community and social determinants of domestic and family violence. The single most common determinant is an inequality of power between men and women that occurs at every level of the system from individual relationships to global levels. Expressions of gender inequality that are the drivers of violence against women include (Our Watch, VicHealth, & ANROWS, 2015):

- Condoning of violence against women.
- Men's control of decision-making and limits to women's independence in public and private life.
- Rigid gender roles and stereotyped constructions of masculinity and femininity.
- Male peer relations that emphasise aggression and disrespect towards women.

Sexual assault and sexual abuse

Sexual assault is a broad term used to describe when a person is forced, coerced or tricked into sexual acts against their will or without their consent, or if a child or young person is exposed to sexual activities. The exact definition of sexual assault varies between jurisdictions and often between agencies within the same jurisdiction. In NSW,

the *Crimes Act 1900* Part 3, Division 10 sets out offences of a sexual nature including sexual assault, indecent assault, sexual intercourse with a child under 16, and grooming a child under 16 for unlawful sexual activity. In addition, the *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* (p. 38) defines sexual abuse with regard to children and young people as:

> Sexual abuse is sexual activity or behaviour that is imposed, or is likely to be imposed, on a child or young person by another person. Sexual activity includes the following: sexual acts; exposure to sexually explicit material; inducing or coercing the child or young person to engage in, or assist any other person to engage in, sexually explicit conduct for any reason and exposing the child or young person to circumstances where there is risk that they may be sexually abused.

'Sexual assault is a crime of violence with serious consequences and requires specialist intervention' (NSW Department of Health, NSW Office of the Director of Public Prosecutions, & NSW Police Force, 2006).

The 2016 Australian Bureau of Statistics' (ABS) Personal Safety Survey (Australian Bureau of Statistics, 2017) found that in Australia:

- Since the age of 15, approximately one in five women (18% or 1.7 million) and one in 20 men (4.7% or 428,800) experienced sexual violence.
- Since the age of 15, approximately one in six women (16.9% or 1.6 million) and one in 23 men (4.3% or 384,800) have experienced sexual assault.
- Sexual assault is much more likely to be perpetrated by someone know to the victim:
    - Since the age of 15, one in five Australian women (19% or 1.8 million) and one in 27 Australian men (3.7% or 330,300) experienced sexual violence by a known person.
    - Since the age of 15, one in 22 Australian women (4.6% or 433,300) and one in 71 men (1.4% or 128,300) Australian men experienced sexual violence by a stranger.
- Women were eight times more likely to experience sexual violence by a partner than men.
- Before the age of 15, almost one in 14 Australians (7.7% or 1.4 million) experienced sexual abuse; which includes almost one in 10 women (10.7% or 1.0 million) and almost one in 22 men (4.6% or 411,800).

Other research also highlights:

- The vast majority (approximately 95%) of perpetrators of sexual assault against both male and female victims are male (Australian Bureau of Statistics, 2017; Australian Royal Commission into Institutional Responses to Child Sexual Abuse, 2017b; M. Stathopoulos, 2014).

- A physically abused woman also experiencing forced sexual activity is over seven times more likely than other abused women to be killed (Campbell et al., 2003).
- Between 4.0-26.8% of Australian females and 1.4-16.0% of Australian males have experienced child sexual abuse (variance depends on methodology including age and definition of abuse) (Australian Institute of Health and Welfare (AIHW), 2018a).
- The majority of children who are abused or neglected experience multiple incidents and types of trauma which has often results in complex trauma and has a significant impact on their development, health (both mental and physical health) and wellbeing (L Bromfield & Miller, 2012; KPMG, 2014).
- The sexual abuse of boys is far more common than generally believed and, in comparison to girls, boys are more likely to be assaulted by siblings or other boys (Australia. Royal Commission into Institutional Responses to Child Sexual Abuse, 2017a; Cashmore & Shackel, 2013).
- Sibling sexual abuse is more prevalent than other types of intra-familial sexual abuse (Australian Institute of Health and Welfare, 2018; Caffaro & Conn-Caffaro, 2005; Tapara, 2012).

Violence, abuse and neglect in Aboriginal communities

'The term "family violence" in an Indigenous context is used to describe the range of violence that takes place in Indigenous communities including the physical, emotional, sexual, social, spiritual, cultural, psychological and economic abuses that may be perpetrated within a family. The term also recognises the broader impacts of violence on extended families, kinship networks and community relationships. It has also been used in the past decade to encompass acts of self-harm and suicide, and has become widely adopted as part of the shift towards addressing intra-familial violence in all its forms' (Gordon et al., 2002; Robertson, 1999; Wild & Anderson, 2007, in Cripps & Davis, 2012). The term 'family' encompasses extended family, kinship networks, and community.

Family violence must be understood and responded to with recognition of the contexts of colonisation, systemic disadvantage, intergenerational trauma, forced removal of children, land dispossession and experiences of racism and discrimination (Blagg, Bluett-Boyd, & Williams, 2015; Cripps & Adams, 2014; Laing & Greer, 2001 in Backhouse & Toivonen, 2018). Responses to family violence must challenge deficit-based thinking by recognising Aboriginal and Torres Strait Islander cultural strength as a key protective factor against family violence. All responses should be community-led, trauma-informed, and built on notions of cultural healing in partnership with Aboriginal and Torres Strait Islander people and communities (SNAICC, NFVPLS, & NATSILS, 2017).

Aboriginal and Torres Strait Islander children continued to be over-represented in the child protection system. In 2016-17, Aboriginal and Torres Strait Islander children were 7 times as likely as non-Indigenous children to have received child protection services (AIHW, 2018a).

- Between 2012-13 and 2016-17, the rate of children receiving child protection services has risen for Indigenous children (from 126.9 to 164.3 per 1,000 (AIHW, 2018a).
- In 2007, one out of five reviewable deaths in NSW were Aboriginal children (NSW Ombudsman, 2008).
- Of all NSW sexual abuse victims aged 15 years and younger, 9.8 per cent were Aboriginal while Aboriginal children make up only four per cent of children in NSW (NSW Ombudsman, 2012).
- Sexual assault of Aboriginal children is widespread and under reported (Aboriginal Child Sexual Assault Taskforce, 2006; NSW Ombudsman, 2012).
- In 2014-15, Aboriginal women were 32 times more likely than non-Indigenous women to be hospitalised due to family violence (Australian Institute of Health and Welfare (AIHW), 2018b).
- There is a gap in the burden of disease between Indigenous and non-Indigenous women. Among Indigenous women aged 18-44 years, the rates of burden due to intimate partner violence are 6.3 times higher than for non-Indigenous women in the same age group (Ayre et al., 2016).
- Existing data indicate that the prevalence and severity of violence affecting Aboriginal and Torres Strait Islander people increases as geographic remoteness increases (AIHW, 2018a).
- 70-90 percent of Aboriginal and Torres Strait Islander women imprisoned in Australia are survivors of sexual and family violence (Walters & Longhurst, 2017).
- The recorded rate of victimisation for sexual assault and child sexual assault is three times higher for Aboriginal people than the total population (Aboriginal Child Sexual Assault Taskforce, 2006).
- The recorded rate of victimisation for domestic violence related assault is six times higher for Aboriginal people than the total population (Aboriginal Child Sexual Assault Taskforce, 2006). Three times as many Indigenous women will experience an incident of sexual violence compared to non-Indigenous women (12% compared to 4%) (Mouzos & Makkai, 2004).

Priority Populations

Violence, abuse and neglect are experienced by individuals and families across all of Australia's communities. However there is sufficient evidence to suggest that particular groups of people and individuals experience multiple challenges that heighten the likelihood, impact or severity of violence, as well as experiencing additional barriers to seeking support and securing safety (Australia. Royal Commission into Institutional Responses to Child Sexual Abuse, 2017a; AIHW, 2018a; Backhouse & Toivonen, 2018).

It is clear from the evidence that domestic and family violence and sexual assault are gendered crimes disproportionately experienced by women and girls and overwhelmingly perpetrated by men (Australian Bureau of Statistics, 2017; AIHW, 2018a). In addition to gender, other factors including age and developmental stage, ability, sexual orientation, Indigeneity, ethnicity, migration and visa status, religion, economic and geographical status and discrimination related to these factors can contribute to increased vulnerability to violence, abuse and neglect for both adults and children that require targeted health and other service responses.

As for all victims, violence, abuse and neglect are rarely experienced as a single incident or caused by a single factor, and are often co-occurring and experienced across the lifetime. However research on the unique characteristics and additional impacts of co-occurrence and re-victimisation for priority population groups[11] is limited. A summary of key findings from literature examining the experience of domestic and family violence, sexual assault and child abuse and neglect for priority population groups is therefore presented below.

Domestic and family violence

When considering domestic and family violence those cohorts with increased vulnerabilities include:

- **Women**: Since the age of 15, one in four women (23% or 2.2 million) compared to one in 13 men (7.8% or 703,000) experienced violence by an intimate partner (Australian Bureau of Statistics, 2017).
- **Aboriginal and Torres Strait Islander people**: Aboriginal and Torres Strait Islander people are significantly more likely to experience family violence than non-Indigenous people (SNAICC et al., 2017). The severity of the violence can be highlighted in the fact that compared with non-Indigenous Australians, Indigenous Australians experience twice the rate of partner homicides in Australia (AIHW, 2018b). More information is outlined in the above section: *Violence, abuse and neglect in Aboriginal communities.*
- **Migrants, refugees and people who are culturally and linguistically diverse**: Immigrant and refugee women tend to seek help only after enduring years of abuse, and are prompted by escalating frequency and severity and fears for the impact on their children (Segrave, 2017).
- **People with disabilities**: Women with disabilities are 40 per cent more likely to experience domestic and family violence than other women and more than 70 per cent of women with disabilities have been victim-survivors of sexual violence (Australian Law Reform Commission, 2010, in Frohmader, Dowse, & Didi, 2015).

[11] **'Priority population'** is a term used to refer to diverse groups for whom there is significant evidence of heightened vulnerability to violence, both in frequency and severity, and who may encounter a range of specific barriers to seeking support and securing safety, related to intersecting identity-based and situational factors and experiences of discrimination. While a range of terminology is used by and to describe these groups, 'priority population' is consistent with the NSW and national policy landscape (Council of Australian Governments, 2011; NSW Ministry of Health, 2018).

- **Lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) people**: One in three LGBTQI Australians have reported experiencing abuse in a relationship, including 65% of transgender men and 43% of intersex women, and lesbian, gay and bisexual people are at greater risk of experiencing sexual coercion than heterosexual females (O'Halloran, 2015).
- **Women with a mental illness**: In 2011, domestic and family violence contributed to more burden of disease (the impact of illness, disability and premature death) than any other risk factor for women aged 25-44. Mental health conditions were the largest contributor to the burden due to physical/sexual intimate partner violence, with anxiety disorders making up the greatest proportion (35%), followed by depressive disorders (32%) (Ayre et al., 2016).
- **Older women**: International evidence suggests women aged over 50 who are victims of domestic violence are suffering in silence because the problem is ignored by professionals and policy makers (Lazenbatt, Devaney, & Gildea, 2013).
- **Women in pregnancy and early motherhood**: During pregnancy, domestic violence can become particularly dangerous and devastating, causing premature birth, serious injury or death to the baby, while also causing detriment to the mother's mental and physical health (Keeling 2012, Manzolli et al., 2009, O'Reilly 2007, Oweis, Gharaibeh & Alhouani 2009 as cite in Cooper, 2013).
- **Women in regional, rural and remote areas**: Women living in regional and remote areas are more likely to have experienced violence since the age of 15 years than those living in major cities (Webster & Flood, 2015).
- **Young women**: Global prevalence of partner violence is 29 per cent among young women aged 15-19, suggesting that violence can occur in women's earliest relationships (AIHW, 2018b).

Child abuse and neglect

In examining current national child protection data, it is evident that those children who were younger, lived in isolated geographic or lower socio-economic communities, or who were Aboriginal or Torres Strait Islander were more likely to have child protection reports made about them substantiated (AIHW, 2018a) as outlined below.

- **Younger children**: Infants (children aged less than 1 year) were most likely to be the subject of a child protection substantiation (16.1 per 1,000 infants), followed by children aged 1-4 years (9.0 per 1,000 children aged 1-4) (AIHW, 2018a).
- **Aboriginal and Torres Strait Islander children**: Nationally, Aboriginal and Torres Strait Islander children were almost seven times more likely to be the subject of substantiated reports than non-Indigenous children (with rates of 43.6 per 1,000 children compared with 6.4 per 1,000 respectively) (AIHW, 2018a)
- **Children living in remote areas**: Children from remote and very remote areas were most likely to be the subject of a substantiation (16.2 per 1000 and 23.5 per 1000 respectively) compared with children in major cities (6.2 per 1000) (AIHW, 2018a).

- **Children living in lower socio-economic areas**: Children in lower socio-economic areas were more likely to be the subject of substantiation than children in higher socio-economic areas, with 6.9 per cent of substantiations occurring in the highest socio-economic areas compared with 35.7 per cent in the lowest socio-economic areas (AIHW, 2018a).

Sexual Assault

Sexual assault is a crime for which the offender is 100 per cent responsible. People often confuse vulnerability with responsibility in the context of sexual assault. There are factors that make people vulnerable to sexual assault such as gender, age, sex, disability, being affected by alcohol or drugs, mental health issues and previous child sexual assault. It is important to remember, however, that sexual assault happens when the perpetrator exploits these vulnerabilities and that does not make the victim responsible for the assault (Yarrow Place Rape & Sexual Assault Service, 2009).

Population groups at higher risk of experiencing and/or having had experienced sexual assault include:

- **Women**: Since the age of 15, approximately one in five women (18% or 1.7 million) and one in 20 men (4.7% or 428,800) experienced sexual violence (Australian Bureau of Statistics, 2017). Women were also eight times more likely to experience sexual violence by a partner than men; approximately one in 20 (5.1% or 480,200) Australian women compared to one in 167 (0.6% or 53,000) Australian men experienced sexual violence by a partner since the age of 15 (Australian Bureau of Statistics, 2017).
- **Young women and girls**: Women aged between 18-34 years were three times more likely to experience sexual violence than men aged 18-34 years or women aged 35 years and over. Before the age of 15 as well, almost one in 10 women (10.7% or 1.0 million) experienced sexual abuse compared to almost one in 22 men (4.6% or 411,800) (Australian Bureau of Statistics, 2017).
- **Aboriginal and Torres Strait Islander women**: Three times as many Indigenous women will experience an incident of sexual violence compared to non-Indigenous women (12% compared to 4%) (Mouzos & Makkai, 2004).
- **Aboriginal children and young people**: Of all NSW sexual abuse victims aged 15 years and younger, 9.8 per cent were Aboriginal while Aboriginal children make up 4 per cent of children in NSW (NSW Ombudsman, 2012).
- **Previous experiences of sexual assault, especially child sexual assault**: Several studies relate that people who have been sexually abused as children are two to three times more likely to be sexually revictimised in adolescence and/or adulthood (Stathopoulos, 2014).
- **People (adults, children and young people) with intellectual disabilities, psychiatric disabilities or complex communication disabilities**: In the 12 months preceding the Personal Safety Survey, for example, 1.5 per cent of all women with disabilities had experienced sexual assault (42,800), compared with 0.8 per cent of women without a disability (45,000) (ABS, 2013, cited in Mitra-Kahn, Newbigin, & Hardefeldt, 2016).

- **People in correctional facilities**: People in correctional and juvenile justice settings who frequently have histories of sexual victimisation (Australian Royal Commission into Institutional Responses to Child Sexual Abuse, 2017b; Clark & Fileborn, 2011; Crome, 2006).
- **Older women**: Across Australia, 344 reports of 'alleged or suspected unlawful sexual contact' were made in residential aged care during 2011-2012 (Mann, Horsley, Barrett, & Tinney, 2014).
- **Children and young people with problematic or harmful sexual behaviours**: Being abused by others (e.g. as a result of poor boundaries and indiscriminate friendliness) (Chaffin et al., 2008). Australian studies find that 30-60 per cent of childhood sexual abuse is carried out by children and young people, and 'most young people target younger children or peers, and know their victim' (Weinrott 1996 as cited in El-Murr, 2017; Evertsz et al., 2012; KPMG, 2014).

Summary of health consequences of violence, abuse and neglect

It is clear that violence, abuse and neglect has serious impacts on an individual's health, contributing to a range of negative health outcomes, including poor mental health, problems during pregnancy and birth, alcohol and other drug use, suicide, injuries and homicide. This health impact is particularly pronounced for women and children where it is estimated that violence:

- contributes more to the burden than any other risk factor in women aged 18-44 years; more than well-known risk factors like tobacco use, high cholesterol or use of other drugs;
- contributes five times more to the burden of disease among Indigenous than non-Indigenous women;
- makes a larger contribution than any other risk factor to the gap in the burden between Indigenous and non-Indigenous women aged 18-44 years; and
- has serious consequences for the development and wellbeing of children living with violence (Webster, 2016).

Although the research exploring the direct health impacts of neglect is currently emerging, and neglect is often grouped with violence and abuse when looking at outcomes, it is clear that the impacts of neglect on children and young people as they grow into adults are profound and include:

- Adults exposed to physical and emotional neglect as children are at elevated risk for internalising distress and substance use behaviour during this developmental period (Cohen, Menon, Shorey, Le, & Temple, 2017).
- Early exposure to childhood neglect is closely associated with the proximal development of depression and anxiety in youth (Hildyard & Wolfe, 2002).
- Children who are being neglected have a myriad of deleterious health outcomes including: obesity; poor immune systems; diabetes; kidney, liver and lung disease; sexually transmitted diseases; increased inflammatory responses; non-normative pubescent development and height; poor oral health; and vision problems. They

also experience a raft of mental health, relationship and behaviour issues (NSW Family and Community Services, 2017a).

A summary of the health consequences of violence, abuse and neglect for women, men and children/young people is provided in the table below. As previously noted, the co-occurrence between the different forms of violence, abuse and neglect and their impact means that it is appropriate to identify these impacts all together.

Physical injuries	• Repeated physical assaults (of adults or children) result in injuries and related health issues such as chronic pain, broken bones, arthritis, hearing or sight deficits, seizures or frequent headaches (Coker, Smith, Bethea, King, & McKeown, 2000). • Analysis of national databases reveal that Indigenous women are 32 times more likely to be hospitalised for injuries related to family violence assaults than non-Indigenous women (Australian Institute of Health and Welfare (AIHW), 2018b). • Children who experience physical violence are at risk of physical injury and death (Doherty, 2003). • Australian research using hospital morbidity data has shown that almost a third of children admitted to hospital with an unintentional injury are known to child protection authorities (McKenzie, Scott, Fraser, & Dunne, 2012). • A common form of abuse affecting the health of babies is shaken baby syndrome. Health problems resulting from shaken baby syndrome may include brain damage, spinal cord injuries, hearing loss, speech difficulties and even death (Child Welfare Information Gateway, 2008).
Death	• Childhood abuse and household dysfunction contribute to the development, decades later, of the chronic diseases that are the most common causes of death and disability (Felitti et al., 1998). • Research suggests that abuse and neglect significantly increases the risk of suicidal ideation and attempted suicide for young people (Hunter, 2014). Approximately three quarters of female homicides are classified as domestic homicides, involving victims who share a family or domestic relationship with the offender (New South Wales Government, 2014). • The World Health Organization (WHO) estimated 31,000 homicide deaths of children aged 15 or younger around the world occur every year (WHO, 2010). This is considered an underestimation as a large number of deaths caused by abuse and neglect go unreported due to being misattributed to other causes such as falls or insufficient investigations and a failure to run post-mortem examinations (Gilbert et al., 2009; WHO, 2010, cited in Hunter, 2014). • Previous contact with child protection services, often with an intergenerational family history, feature as a common denominator in child deaths across Australia (Goldsworthy, 2017). • Medical neglect (from failure to heed obvious signs of serious illness or failure to follow a physician's instructions once medical advice has been sought for a child/young person) can be fatal in some cases or can lead to chronic disability (Jenny, 2007).

Mental health	• Violence against women has been identified as a determinant of mental health and wellbeing (VicHealth, 2008). • Violence and abuse increase the risk of depression, post-traumatic stress disorder, sleep difficulties and insomnia, eating disorders, self harm, suicidal thoughts, anxiety, suicide and emotional distress (Black et al., 2012; Campbell, 2002; Cryan & Dinan, 2013; Gunnar & Quevedo, 2007; S. E. Moore et al., 2015; Wekerle & Wolfe, 2003; Whitfield, Anda, Dube, & Felitti, 2003). • Childhood adversities including family violence, physical abuse and neglect are the strongest correlates of onset of adult psychiatric disorder (Green et al., 2010). • Childhood exposure to violence increases children's risk of mental health, behavioural difficulties, learning difficulties, and poor educational outcomes in the short-term and later in life (Campo, 2015; Rossman, 2001; Whitfield et al., 2003). • Children and young people who have been neglected experience a myriad of mental health issues including: eating disorders, depression, anxiety disorders, psychosis, personality disorders, early onset bi-polar disorder, and self harm/suicidal ideation and behaviour (NSW Family and Community Services, 2017a).
Physical health	• A longitudinal study compared children with documented experiences of physical abuse, sexual abuse and/or neglect with non-maltreated children, following these cohorts over 30 years. The study found a number of medical problems in adulthood which were associated with childhood neglect and physical abuse, such as increased risk of diabetes, poor lung functioning, poor visual and oral health and high risk factors associated with heart disease (Widom, Czaja, Bentley, & Johnson, 2012). • The Adverse Childhood Events (ACE) study involving more than 17,000 people identified ten categories of childhood experience that accurately predicted health concerns in adults. The more adversities a child experienced, the greater the number of health concerns they experienced. The numerous physical health problems in adulthood associated with these experiences include increased likelihood of autoimmune diseases (Dube et al., 2009), heart disease (Anda et al., 2008; Dong, Dube, Felitti, Giles, & Anda, 2003), liver disease (Dong et al., 2003), and cancer (D. W. Brown et al., 2010). • Stroke, diabetes, skeletal fractures, and poor self-rated health as an adult (Anda et al., 2008; Dong et al., 2003; Dube et al., 2009). • Chronic health conditions can be seen in victims of abuse indirectly through long term psychological stress include stomach ulcers, spastic colon, frequent indigestion, diarrhoea, constipation, angina and hypertension (Coker et al., 2000). • At a time of rapid neurological growth, an infant's physical and emotional development may be compromised by exposure to ongoing violence, whether or not they are the target of the violence (Rossman, 2001). • Women who have experienced sexual assault suffer ongoing physical problems such as chronic diseases, headaches, irritable bowel syndrome, eating disorders and gynaecological conditions (World Health Organisation (WHO), 2002).

Sexual and reproductive health	• Sexual assault, domestic and family violence and child sexual abuse is associated with sexually transmitted infections (including HIV/AIDS), unintended/unwanted pregnancies, gynaecological problems, induced abortions, and adverse pregnancy outcomes, including miscarriage, low birth weight and foetal death (Australian National Council to Reduce Violence Against Women and Their Children, 2009; World Health Organisation (WHO), 2002).
Behaviours associated with risk	• Victims of abuse are much more likely to engage in activities that are seen to be linked to risk. These include smoking, poor nutrition, physical inactivity, unprotected sex and substance use and dependence. These actions may be adopted as coping strategies for the victim-survivor (Campbell, 2002; Coker et al., 2000; Great Britain. Taskforce on the Health Aspects of Violence against Women and Children, 2010). • Victims of abuse have higher levels of alcohol and drug misuse during both adolescence and adulthood (Fergusson & Lynskey, 1997; Harrison, Fulkerson, & Beebe, 1997; Perkins & Jones, 2004) with evidence suggesting that all types of child maltreatment are significantly related to higher levels of substance use (tobacco, alcohol and other drugs) (Moran, Vuchinich, & Hall, 2004). • Some studies show the rates of child sexual assault amongst women in drug and alcohol programs is between 47%-74% (Jarvis & Copeland, 1997). • Childhood experiences of violence and abuse are well-documented risk factors for a number of adverse psycho-social outcomes including: behavioural problems in childhood and adolescence (Campo, 2015; Ethier, Lemelin, & Lacharité, 2004; Mills, 2004; Shaffer, Huston, & Egeland, 2008) and attachment and interpersonal relationship issues and using violence themselves (Gilbert et al., 2009; Maas, Herrenkohl, & Sousa, 2008). This places the child or young person at risk of exposure to further violence from others (e.g. as a result of poor boundaries and indiscriminate friendliness) (Chaffin et al., 2008) or responding to their violent behaviour. • Children with problematic or harmful sexual behaviour can be at increased risk of this behaviour escalating and continuing into adolescence (Silovsky & Niec, 2002).

Appendix 2: NSW Health responses to violence, abuse

Responding to violence, abuse and neglect, and by extension children and young people with problematic or harmful sexual behaviour, is the responsibility of the whole health system. Nevertheless, some NSW Health services have particularly important roles and responsibilities in the prevention, identification and response to violence, abuse and neglect. An outline of these NSW Health services is provided below divided in three conceptual categories based loosely on the public health approach (see Section 1.2):

1. ***Violence, Abuse and Neglect (VAN) Services****:* NSW Health services with principle responsibility for responding to either specific types of violence, abuse and neglect (i.e. child abuse and neglect, domestic and family violence, sexual assault, and children and young people with problematic or harmful sexual behaviour) or that provide an integrated VAN service. These services work across the continuum of prevention from primary, secondary and tertiary prevention and universal, selected and indicated interventions.
2. ***Secondary responses to violence, abuse and neglect****:* activities and programs within services whose primary principal responsibility is not violence, abuse and neglect, however, they provide services to people who have experienced, or are at heightened risk of experiencing or perpetrating, violence, abuse and neglect. Responses from these services may include activities across the spectrum of primary, secondary and tertiary prevention. Responses may specifically identify and/or respond to violence, abuse and neglect (e.g. Routine Screening for Domestic Violence or treatment of violence-related injury in an Emergency Department) or may indirectly reduce risks, vulnerabilities, and short or long-term impacts associated with VAN (e.g. mental health or drug and alcohol interventions).
3. ***Primary responses to violence, abuse and neglect***: universal services, interventions and initiatives aimed at the general population or specific groups in the population without regard to their individual risk of violence, abuse and neglect. Responses from these services focus indirectly on primary prevention of violence, abuse and neglect by delivering services that reduce vulnerability and risk such as by supporting vulnerable families. Similarly to secondary responses, some of these services may work with populations at heightened risk of either experiencing violence or where the impact of the violence is likely to be more severe due to the vulnerabilities of the people involved (e.g. in pregnancy and early childhood). In this context, however, direct responses tend to focus on early intervention by identifying people who have experienced, or are at risk of experiencing, violence, abuse and neglect and referring them to the appropriate service.

As is often the case with conceptual models, these categories are ideal types and an individual service response or intervention may appropriately be categorised in more than one of these categories. The most relevant NSW Health services and interventions responding to violence, abuse and neglect are therefore outlined in the tables below in the category that is most appropriate, while acknowledging potential overlaps in practice.

Violence, Abuse and Neglect (VAN) Services

Service	Description
Aboriginal Family Wellbeing and Violence Prevention Program (AFWVP)	The Aboriginal Family Wellbeing and Violence Prevention Program (AFWVP) aims to reduce the incidence of family violence in Aboriginal communities through a mixture of prevention, early intervention and community development activities. AFWVP workers provide critical support to families dealing with family violence. The core role includes individual and family support activities, initial crisis support advocacy and referral to other services, as well as broader community development and education strategies, with a focus on prevention and early intervention. There are 25 AFWVP workers employed in prioritised areas, predominantly in Aboriginal Community Controlled Health Services (ACCHSs) in regional areas and within the Justice Health system. There are also four Aboriginal Family Health Coordinators employed in Local Health Districts throughout the state as part of the AFWVP.
Child Protection Counselling Services	Child Protection Counselling Services are located in each Local Health District and are a trauma-specific service which responds to the violence, abuse and neglect of children. CPCS also work towards the recovery and ongoing safety and wellbeing of children involved with the care and protection system. CPCS provide services to children and young people up to the age of 18 years and their families/carers who have experienced, or are believed to have experienced: physical or emotional abuse; sexual abuse; neglect; and/or exposure to domestic and family violence. CPCS also work with children under 10 years displaying problematic or harmful sexual behaviours where this is a secondary presenting issue, and other violence, abuse and neglect issues where these impact on the care and safety of children and young people. CPCS aim to support children to achieve safety, security and permanency through family preservation, family restoration, or moving to a sustainable long-term placement.
Child Protection Units/Teams	NSW Health has three specialist hospital-based Child Protection Units/Teams located within the Sydney Children's Hospitals Network at Westmead and at Randwick, and Hunter New England Local Health District. These provide tertiary child protection services for children and young people who have experienced physical, sexual, and emotional abuse, domestic violence, and neglect. They provide comprehensive paediatric medical, forensic and psychosocial assessments and treatment. Each of the child protection services has access to medical imaging and pathology services, intensive care, surgery and other subspecialties. Child protection medical consultants are available for medical consultation and second opinions to staff across NSW.
Child Wellbeing Units (CWUs)	The NSW Health Child Wellbeing Unit is a support service staffed by child protection professionals proficient in the assessment and management of risk to children and young people.

Service	Description
	All NSW Health workers can contact the NSW Health Child Wellbeing Unit via telephone, or by eReporting, to seek advice if they have concerns about the safety, welfare or wellbeing of a child, young person or unborn child. The CWU can: • Provide advice and information to clearly identify child protection risks, harm and vulnerabilities • Advise on interventions, treatments and/or referrals for vulnerable or at risk children, young people and families • Provide relevant information held about past child protection related concerns • Provide guidance about how to raise health, safety and wellbeing concerns with parents • Where required, escalate suspected risk of significant harm matters to the Child Protection Helpline.
Domestic Violence Services	NSW Health currently has a small number of specific domestic violence services, the St George Domestic Violence Service which provides supports such as early intervention programs, safety planning, risk assessment and counselling (individual/group work). These services can also support local prevention work, capacity building and collaborative practice/partnership with government and non-government partners.
Education Centre Against Violence (ECAV)	The NSW Health Education Centre Against Violence (ECAV) has been established for over 30 years as a state-wide unit responsible for workforce development in the specialist areas of prevention and response to violence, abuse and neglect, including a specific focus on Aboriginal and Cultural and Linguistically Diverse Communities (CALD). ECAV provides statewide face-to-face and online worker training, community awareness and development programs, agency and policy consultation, clinical supervision and resource development for NSW Health and other government and non-government organisations. ECAV Manages a number of statewide NSW Health workforce development initiatives such as the Adult Sexual Assault Medical & Forensic Care; Violence, Abuse & Neglect Specialist Support & Counselling Services; Aboriginal Family Wellbeing & Violence Prevention Network; Domestic Violence Routine Screening Implementation; and Child Protection Facilitator Training. ECAV has four training portfolio areas: 1. Aboriginal programs 2. Sexual Assault, Child Protection & Joint Child Protection Response Program

Service	Description
	3. Domestic Violence & Cultural Equity 4. Male Domestic & Family Violence Interventions ECAV has a dual governance structure; the Prevention and Response to Violence, Abuse and Neglect (PARVAN, MoH) provides strategic leadership and Integrated and Community Health, WSLHD oversee operational functions.
Joint Child Protection Response Program	NSW Health is an equal partner in the Joint Child Protection Response Program (the Program), working jointly with NSW Police Force and the Department of Family and Community Services (FACS). The Program, which was formerly Joint Investigation Response Teams (or JIRT) provide services across NSW. It provides a comprehensive and coordinated safety, criminal justice and health response to children and young people alleged to have suffered sexual abuse, serious physical abuse or extreme neglect. Specifically, the Program's role is to undertake joint investigations of statutory child protection matters that require a criminal justice response. The Program's model aims to deliver improved outcomes for vulnerable children and young people and their family members or carers. NSW Health is responsible for providing an integrated medical and psycho-social response to the Program's clients who are victims of sexual assault, serious physical abuse and extreme neglect and their families/carers. A small team of clinicians is employed to work in the Joint Referral Unit (JRU) on joint decision-making around intake to the Program. JRU Health staff work closely with health services to provide timely health information about JIRT clients and to arrange urgent health service provision where required. NSW Health also employs clinicians in the 22 JIRT units around NSW where they work with the partner agencies on local planning and coordinated service responses for the Program's clients.
Kaleidoscope (Sparks)	The Sexualised Behaviour Program for Children Under 10 (Sparks Clinic) is a NSW Health service that has developed a specific service model for children under 10 who have displayed problematic or sexually harmful behaviours. This service is based in the Hunter New England Local Health District (HNELHD). The role of the Sparks Clinic includes: to provide clinical intervention in the Greater Newcastle area to children under 10 with problematic or harmful sexualised behaviour (and their caregivers); to be available to provide education/training to government and non-government agency staff who deal with children; and to provide consultation/education and training to Health Professionals within the HNELHD to assist their intervention with children under ten that present with problematic or harmful sexualised behaviour and their caregivers.
New Street	New Street Services provide specialised, community-based, early

Service	Description
Services	intervention to young people aged 10-17 who have engaged in sexually harmful behaviours and have not been charged with the offence as well as their non-offending family members/significant others and carers. New Street uses a child protection framework that addresses the safety, welfare and wellbeing of: children and young people who have been sexually harmed; other children and young people surrounding the child or young person who has been sexually harmed; and the child or young person aged 10-17 years who has displayed harmful sexual behaviour. There are currently New Street Services provided by a number of Local Health Districts including Western Sydney, Hunter New England, Western NSW, Illawarra Shoalhaven, Murrumbidgee, and Northern NSW.
Sexual Assault Services (SASs)	NSW Health has a network of specialist Sexual Assault Services (SAS) delivered by Local Health Districts. Every Local Health District has a Sexual Assault Service that operates 24 hours a day, seven days a week. Sexual Assault Services provide services to: • Clients/patients: psychosocial services including crisis and ongoing counselling, case work, provision of information and support; a specialised medical service which always includes general health and wellbeing assessment and treatment, if needed, and can include the collection of evidence (e.g. DNA) related to the assault for legal purposes; support for non-offending family members, significant others and carers; advocacy; and court preparation, court support and court reports. • Professionals: training; consultation; networking; and interagency forums. • Community: education; awareness raising; and prevention.
Specialist Services for Children and Young People in Out-Of-Home Care	OOHC coordinator positions have been appointed in all LHDs across NSW. Out-of-Home Care coordinators facilitate the coordination and delivery of health assessments for children and young people entering out-of-home-care. A joint Alternate Care Clinic is provided by Redbank House (a specialist child and adolescent mental Health Service at Westmead Hospital) and The Children's Hospital Westmead, in partnership with Community Services. The Clinic assists carers in understanding and addressing the mental health needs of young people in out-of-home care. The clinic accepts referrals from Community Services Metro West and the Metro Intensive Support Service. As part of SWSLHD CAMHS, an OOHC Program delivers specialist mental health services to children and young people living in Out of Home Care (OOHC) in SWSLHD who have severe and complex mental health problems, including behavioural and emotional disorders of childhood and adolescence. The OOHC team uses robust and

Service	Description
	evaluated models of service delivery for this population such as the Alternate Care Clinic based at Redbank House (Western Sydney LHD) and the successful partnership model between SWSLHD and the Metro ISS residential service, Sherwood House. The model has an outreach and home-based service delivery focus.
Whole Family Teams (WFT)	WFTs provide specialist mental health and drug and alcohol services for families in their home, where there are mental health and/or drug and alcohol problems and children are at Risk of Significant Harm (ROSH). Referrals from Community Services are prioritised. Teams provide intensive medium term interventions for both children and parents averaging approximately 8+ months that include: • Assessment of family functioning. • Comprehensive and integrated mental health and drug and alcohol assessment of individuals. • Comprehensive care planning that includes specialist individual and family evidence based treatments. • Assertive outreach in a partnership model between Mental Health, Drug and Alcohol and Community Services. Whole Family Teams are located in the Illawarra Shoalhaven; Northern NSW; Central Coast; Western Sydney; Nepean Blue Mountains; South Western Sydney and Newcastle Local Health Districts.

Secondary responses to violence, abuse and neglect

Service	Description
Adult Mental Health Services	Mental health services in NSW are provided across a service spectrum including primary care services, specialist mental health treatment and community-based supports. NSW Health is primarily responsible for delivering specialist mental health and general health services for people with severe and complex mental illness in both inpatient and community settings. NSW Health also commissions community managed organisations (CMOs) to provide services to support people living with and recovering from mental illness.
Alcohol and Other Drug (AOD) Services	NSW Health delivers a comprehensive range of alcohol and other drug treatment and support services across government and non government organisations that are designed to meet the needs of individuals, families and communities. They include: psychosocial support, case management, care coordination, hospital-based consultation liaison, withdrawal management, day programs, residential rehabilitation and continuing care. Targeted programs include the opioid treatment program and substance specific approaches such as the Stimulant Treatment Program and Cannabis Clinics, Programs such as the Assertive Community Management

Service	Description
	services and the Involuntary Drug and Alcohol Treatment Program aim to support the more vulnerable populations as well as diversion programs such as Magistrates Early Referral Into Treatment (MERIT) and Drug Court.
Substance Use in Pregnancy and Parenting Services	All local health districts provide support for pregnant women with substance use issues, many with designated Substance Use in Parenting and Pregnancy Services (SUPPS). The aim of SUPPS is to provide specialist best practice care across NSW for substance using pregnant women and their children to improve and sustain their health outcomes in NSW. The SUPPS is a coordinated multi-disciplinary service that supports pregnant women who use substances from the antenatal period to two years post-delivery. The services facilitate delivery of best practice care for pregnant women as well as access to expertise and advice on clinical management of pregnant women for peri and antenatal services.
Residential Treatment Services for Substance Using Women and their children	There are five specialist residential alcohol and other drug services across NSW that provide AOD treatment and support to substance using women, including services for pregnant women and women with children. These non-government services deliver a gender responsive approach that attends to the experiences of women, are child sensitive and focus on parenting skills and strengthening family relationships.
AOD Support for Families	Support services for people affected by the AOD use of a family member are provided by Family Drug Support, a 24/7 telephone support service. Additionally, the 'Your Service Hub' provides a comprehensive online directory of health and community services across NSW for individuals and family members to find the support services they need. Support is also available specifically for the families of young people undergoing treatment to develop resilience and coping strategies, and provide them with information and referral to appropriate family support services.
Youth AOD services	A number of youth specific services, delivered by NGOs and LHDs offer multidisciplinary support for young people and their families, including withdrawal management, residential rehabilitation, psychosocial support, care coordination and counselling. Specialist medical support is also available through the Children's Hospitals in Sydney and Newcastle to holistically address the harms related to young people and substance use.
Child and Adolescent	Specialist Child and Adolescent Mental Health Service (CAMHS) provide mental health services for children and young people, (aged

Service	Description
Mental Health Service	0-17 years inclusive) with moderate to severe mental illness and their families and carers. They provide evidence-informed, family-oriented, clinical mental health assessment, care planning, intervention and consultation-liaison services. CAMHS service settings include community-based day programs, non-acute inpatient, acute inpatient, and intensive family interventions. Online and e-health treatments are incorporated in service delivery.
Domestic Violence Routine Screening	Domestic Violence Routine Screening is designed to identify women experiencing or at risk of experiencing domestic violence. It provides information to at-risk populations, and also provides an early intervention response to all women attending antenatal services and Early Childhood Health services and women 16 years and over attending Alcohol and Other Drugs Services and Mental Health Services. In addition to being asked questions about experiences of domestic violence within the past 12 months, all women are provided with written information about domestic violence regardless of whether they disclose.
Emergency Departments	Hospital emergency departments provide urgent treatment to people suffering from a serious illness or injury that could get worse if not treated quickly. Emergency departments are in many public hospitals across NSW and are open 24 hours a day.
Family Care Centres	Family Care Centres (also known as Family Care Cottages) are a secondary level of service, supporting the services of early childhood health providers at the primary service level. Family Care Centres offer clients an intensive intervention for problems that need longer appointments or a multidisciplinary focus. They have day stay facilities for the more complex developmental, behavioural, feeding, sleeping and adjustment problems of infancy. The Family Care Centre is part of the network of services for families with children 0-5 years provided by a local health district. These centres may be staffed by child and family health nurses, mothercraft nurses, social workers and psychologists who provide more intensive support, education and advice to families with children 0-5 years of age. Parents may be referred by general practitioners, child and family health nurses, social workers, or hospitals. Problems not able to be resolved at this level may be referred to the next level of service Residential Family Care Services. Residential Family Care Services in NSW provided by Tresillian and

Service	Description
	Karitane offer intensive specialist support and care for complex parenting problems. A referral from a Health professional is required for admission to a Residential Family Care Unit, which are staffed by specially trained registered nurses, mothercraft nurses, social workers, and psychologists, and are supported by paediatricians and psychiatrists. Parents may live in for up to a week for problems such as unsettled babies, crying babies, feeding problems, behavioural problems, depression and complex psychosocial problems. There are also special units for toddler management and advice. Tresillian and Karitane are Affiliated Health Organisations that also offer a range of services including day stay services, outreach services, parent group programs, home visiting, 24 hour crisis telephone services and professional education programs.
Family Referral Services (FRS)	Family Referral Services (FRS) provide statewide coverage from 11 locations, and assist children, young people and families who do not meet the statutory threshold for child protection intervention, but may benefit from services to address current problems and prevent escalation. FRS link vulnerable children, young people and their families with the most appropriate available support services in their local area, and Health workers are able to make referrals to FRS. FRS can assist with accessing services including, but not limited to: • Domestic violence support services, including counselling • Housing and accommodation services • Financial assistance • Counselling and mediation • Parenting support services, including parenting programs • Mental Health support services • Culturally appropriate support services.
Local Coordinated Multiagency Offender Management	Local Coordinated Multiagency Offender Management (LCM) is a key initiative aimed at achieving the Premier's Priorities and the State Target to reduce reoffending generally and domestic and family violence reoffending more specifically. LCMs involve multiple agencies including NSW Police Force, Department of Justice, Family and Community Services and NSW Health. The system is designed to facilitate the sharing of information and the development of collaborative, shared case plans for a small number of priority reoffenders, designed to reduce an individual's risk of reoffending. LCM meetings are pending roll out in a limited number of locations throughout the state. Mental Health, Alcohol and Other Drugs and Violence Abuse and Neglect areas collaborate on the implementation of this trial.
SAFE START	SAFE START is a model of care that aims to improve the early

Service	Description
	identification of parental mental health problems through screening in pregnancy and in the early months of parenting a new baby. The SAFE START model provides a consistent model for psychosocial assessment and depression screening for women expecting or caring for an infant. When parental mental health problems are identified, SAFE START aims to reduce the relapse rate and lower the impact of parental mental illness on the infant, while preserving the family unit. SAFE START consultation and liaison positions have been funded across NSW, and provide essential mental health consultation and liaison functions across mental health, drug and alcohol, maternity, child and family, general practitioner and other services for families with multiple and complex needs during the peri-natal period.
Safety Action Meetings	Safety Action Meetings (SAMs) are a key element of Safer Pathway within the 'It Stops Here' NSW Government Domestic and Family Violence Reforms. NSW Health participates in all SAMs throughout NSW. SAMs are regular meetings of local service providers that aim to prevent or lessen serious threats to the safety of domestic violence victims and their children through targeted information-sharing, facilitating their access to domestic violence support services, promoting earlier intervention and reducing their stress and trauma. Members share information to develop tailored, time-specific Safety Action Plans for victims at serious threat and their children. NSW Health provides relevant information at SAMs relating to listed victims, perpetrators and their children, or children and young people in their care. NSW Health staff also instigate actions arising from Safety Action plans.
Service for the Treatment and Rehabilitation of Torture and Trauma Survivors	The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors is an affiliated Health service which addresses the needs of traumatised refugees, particularly those who have been tortured as part of their ordeal. Services include torture and trauma counselling to individuals and families, health assessments and referrals, group work for young people and adults and adjuncts to therapy such as limited employment and training assistance. Other services provided include community education and awareness raising about the health and psychosocial issues affecting torture and trauma survivors; training for service providers to develop their skills to work with traumatised refugees; and consultation with organisations to enhance the appropriateness and effectiveness of their services for refugee communities.
Sustaining NSW Families	Sustaining NSW Families is one kind of sustained, nurse-led health home visiting service that operates in NSW. The Sustaining NSW

Service	Description
	Families program operates in eight local health districts (as at 2018) across NSW to support vulnerable infants, young children and families. The program aims to improve developmental outcomes for children, through a structured program that is delivered through intensive nurse-led health home visiting that ideally commences in pregnancy and continues through to the child's second birthday. The nurses are supported to deliver the program by a team of allied health professionals. The program has been shown to improve social and emotional developmental outcomes for children through fostering the development of: parental self-efficacy; the early attachment relationship; and awareness of the developmental needs of the infant. Families that are likely to benefit most from the program are identified through the SAFE START assessment. Program eligibility includes mothers with or at risk of post-natal depression: young, first time, isolated or vulnerable mothers and other risk factors that require a Level 2 service response (p. 17, *Maternal and Child Health Primary Health Care Policy).*
Youth Mental Health Services (Mid North Coast; Illawarra Shoal Haven; South east Sydney; Western NSW; Central Coast)	The Youth Mental Health Services Model targets young people aged 14 to 24 years to increase early access to mental health services. The Youth Mental Health Services Model promotes enhancing awareness of mental health across the community, stakeholder groups and service networks. The focus of the model is on early intervention and prevention of disability associated with onset of mental illness, with flexible approaches to service provision, and to a range of health and support services relevant to young people. These services provide evidence-based interventions linking specialist youth mental health services, headspace, general practitioners, drug and alcohol workers and other relevant services.

Primary responses to violence, abuse and neglect

Service	Description
Aboriginal Maternal and Infant Health Service (AMIHS)	AMIHS is a maternity service for Aboriginal families that aims to improve health outcomes for mothers and babies. AMIHS uses a continuity-of-care model where Aboriginal health workers and midwives work together, and with other services, to provide high quality antenatal and postnatal care. Care starts as early as possible in pregnancy and continues up to eight weeks postpartum, The care is provided in the community and is linked into mainstream maternity services. Key elements of the AMIHS service model includes: • being accessible, flexible and mobile

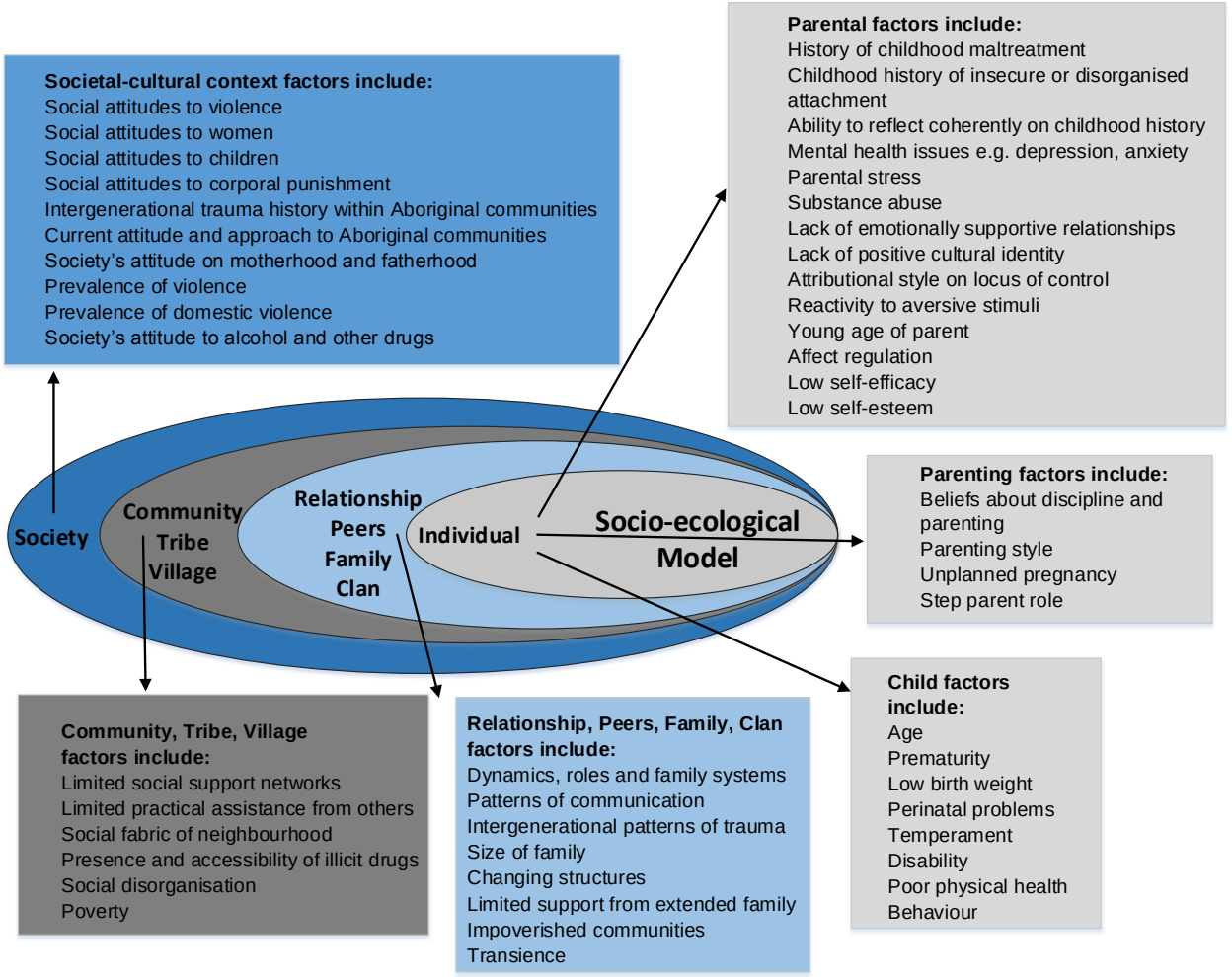
Service	Description
	• working with other services to provide integrated care for women and families • being involved in community development and health promotion activities • supporting women and families to transition from AMIHS to child and family health services. There are over 40 AMIHS sites across NSW delivering services in over 80 locations. Most AMIHS are delivered by local health districts and some are delivered by Aboriginal Community Controlled Health Services.
Building Strong Foundations for Aboriginal Children, Families and Communities (BSF)	BSF programs provide culturally safe and secure early childhood health services (0-5 years) to Aboriginal families. BSF services are provided by teams of Aboriginal health workers and child and family health nurses. In some locations, the core team is supported by other allied health professionals including social workers. The BSF service works with families, parents, carers and the local community, to support the health, growth and development of Aboriginal children so they are able to fully engage in life and learning. These services have strong links to Aboriginal mothers and babies programs such as AMIHS and the Commonwealth-funded program New Directions for Mothers and Babies as well as to mainstream maternity and child and family Health Services. BSF services are located in 15 sites across NSW.
Child and Family Health Services	Child and Family Health Services are staffed by child and family health nurses and provide well child health care to children from birth to school age, and their families. The services offer well child health checks (which are described in the NSW Personal Health Record, or 'Blue Book' that each child receives at birth), support with feeding, sleeping and caring for children in the early weeks, months and years of life. The services are provided by child and family health nurses. Child and family health nurses offer a range of services including information, advice and support on parenting and child health matters, assessment of children's growth and development, early identification of child abuse and postnatal depression, health promotion including child safety, parenting groups and referral to community and specialised services. Child and family health nurses work in partnership with other departments and agencies for the assessment and care of children and for developing and conducting programs.
Maternity	Are provided in more than 70 maternity units in public hospitals across

Service	Description
Services	NSW. These services assist with the majority of births in NSW. A range of services are offered to pregnant women including antenatal care, Early Pregnancy Assessment Services for those women experiencing problems in early pregnancy, birthing services, and post natal care. Services are offered through a variety of models of care, including continuity of care and more specialised care for those women identified as moderate or high risk. Universal psychosocial assessment, depression screening and domestic violence screening are implemented in maternity services (see SAFE START). Where risks and high needs are identified, women are referred to specialist services, including perinatal mental health services. Maternity clinicians participate in multidisciplinary processes to consider and coordinate the care and support of women and families with complex needs.
'The Mums and Kids Matter' (MaKM) Program	'The Mums and Kids Matter' (MaKM) Program provides mothers with mental illness and their children (0-5 years) specialist, short-term, non-acute residential mental health and tertiary parenting care; in-home or residential care accommodation and support packages; and brokerage for additional specialist care packages. MaKM aims to provide integrated and stepped care for mothers with complex mental health concerns and their children in the community, avoiding unnecessary hospitalisation and separation of mothers and their children. MaKM provides a consumer driven, recovery focus of treatment that includes comprehensive services and intensive support. Referral is through public mental health services and care planning and support is delivered using a co-ordinated, shared care approach with a range of providers from Mental Health, Drug & Alcohol, Family and Community Services, non-government and community services and organisations. The program links mothers to a range of community-based local supports according to each mother's needs and preferences and the needs of her children. It aims to decrease out of home care and homelessness through the provision of social, parenting and health support for mothers, their children and families.
Perinatal and Infant Mental Health Service	The specialist Perinatal and Infant Mental Health Service (PIMHS) is provided statewide through LHDs for pregnant women and mothers with severe and complex mental illness of infants up to two years of age. PIMHS supports the woman's recovery, mother-infant relationship, parenting and family functioning. PIMHS provides hospital in-reach as well as in-home support to women, their partners and families, reducing separation of mothers from their infants wherever possible. The service includes a Statewide Outreach Perinatal Service for mental health (SwOPS-mh) to ensure that families living in rural and remote districts have access to specialist expertise from a metropolitan hub.

Service	Description
	PIMH treatment and care is also available to perinatal women in custody through Justice Health & Forensic Mental Health. There are PIMH clinicians located in all local health districts, where they work closely aligned with adult mental health services. The service works in close collaboration with primary (e.g. Sustained Home Nurse Visiting), secondary care providers (e.g. Karitane, Tresillian, The Gidget Foundation) and other tertiary services (e.g. St John of God, Mums & Kids Matter).
Pregnancy Advice Line	The Perinatal Advice Line provides high level telephone advice to clinicians and ambulance staff on the management and emergency transfer of women with complicated pregnancies in NSW who require a higher level of care.
Universal Health Home Visiting	NSW Health's policy is that parents are offered at least one universal contact in the family's home within two weeks of birth by a child and family health nurse from their Child and Family Health Service. This is known as the Universal Health Home Visit (UHHV). The aim of UHHV is to engage all families with newborns into the services that provide them with care and support after the birth of their baby. During the visit, the nurse will conduct the 1-4 week scheduled well child health check, and provide support to parents depending on the individual needs of the baby and family. The offer of a UHHV seeks to make it easy for parents to use the services that can support them in the early weeks of their child's life, help with the early detection of possible health and development issues, and provide a strong initial assessment that takes the home environment of the family into account.
Women's Health Centres	The Women's Health Centres (WHCs) funded by NSW Health, and the non-government sector more broadly, provide multiple primary health and wellbeing services to a significant number of women in NSW, including access to generalist and specialist counselling (particularly for sexual assault and domestic and family violence), information and referral, and medical appointments with female or gender-appropriate clinicians. Clients may self-refer, or be referred by other NGOs and LHD services.
Youth Health Services	Youth health services provide a range of specialist services for children and young people aged between 12 and 24 years. These services may include a specific focus on first episode/early psychosis; specialist mental health outreach interventions for young people and their family; group work; psych-education; cognitive behavioural therapy; specialist interventions for children counselling and casework services; health promotion; nursing and medical services; drug and alcohol counselling; counselling for children and young people who are at risk of significant

Service	Description
	harm or where abuse has been identified; counselling for children and young people where sexual assault has not been positively identified; outreach services; and needle exchange services.

Appendix 3: Socio-ecological model for violence, abuse and neglect involving children



Socio-ecological model for violence, abuse and neglect involving children (adapted from ECAV's version of WHO 2002 & 2004)

Appendix 4: Legislative and policy context

Legislation and policies of particular relevance to violence, abuse and neglect involving children.

Legislation

- *Children and Young Persons (Care and Protection) Act 1998 (NSW)* Chapter 14 includes a range of child abuse and neglect offences involving children and young persons. Chapter 16A concerns the exchange of information about a child or young person and coordination of services. Section 245C of the Act allows a prescribed body to provide information of their own accord to another prescribed body that relates to the safety, welfare or wellbeing of a particular unborn child, child, young person or 'class of children' or young persons.
- *Child Protection (Working with Children) Act 2012 (NSW)* stipulates that only people with valid Working with Children Checks are engaged in child related work (where a child is under the age of 18 years) — refer to the NSW Health Policy on *Working with Children Checks*.
- *Crimes Act 1900 (NSW)* Part 3 of the Act lists 'Offences against the person' which includes a range of potentially relevant crimes related to violence, abuse and neglect involving children. This includes homicide: (Division 1), acts causing danger to life or bodily harm (Division 6), assault (Division 8), assaults etc. at schools (Division 8B), rape and sexual assault (Division 10), kidnapping and child abduction (Division 14), child prostitution (Division 15), and child abuse material (Division 15A).
- *Crimes (Domestic and Personal Violence) Act 2007 No 80 (NSW)* Part 3 defines domestic violence and other offences. Chapter 13A enables the exchange of information in accordance with the related protocol to facilitate access to domestic violence support services for people at serious threat.
- *Commonwealth Crimes Act 1914*
- *Evidence Act 1995 (NSW)* Part 3.10 deals with the privileges that may bar admissibility of evidence, one of which (Division 1B) is for confidential communications made about sexual assault.
- *Family Law Act 1975* (C'th) The Act states that when a court is considering a child's best interests the court is to give greater weight to protecting children from the risk of violence, which is a primary principle (along with the right of children to have a meaningful relationship with both their parents). This means that children must be protected from the direct harm of violence and the harm that results when they are exposed to family violence against other family members. This includes sexual assault or other sexually abusive behaviour.
- *Guardianship Act (NSW)*
- *Health Records and Information Privacy Act 2002 (HRIP Act) (NSW)*

- *Mental Health Act 2007 (NSW)*
- *Ombudsman Act 1974 (NSW)* prescribes the responsibilities of heads of agencies for preventing, and for responding to, allegations, charges or convictions of a child protection nature against staff (where a child is defined as being under 18 years). This extends to allegations relating to conduct that has occurred outside of work or prior to the staff member's engagement, including historic matters where the alleged victim may now be an adult. Refer to the NSW Health policy on *Child Related Allegations, Charges or Convictions against NSW Health staff*.
- *Privacy and Personal Information Protection Act 1998 (PPIP Act) (NSW)*
- *Victims Rights and Support Act 2013* (NSW) requires that any person or agency exercising official functions in the administration of the affairs of the State, must (to the extent that it is relevant and practical to do so) consider the *NSW Charter of Victims Rights* (see further below) in their interaction with a victim of crime.

Policies

- The *Child Wellbeing and Child Protection — NSW Interagency Guidelines* provide information and guidance to organisations involved in the delivery of child wellbeing and child protection services in NSW.
- The *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* outlines mandatory reporting and other legal responsibilities of Health services and Health workers to promote the health, safety, welfare and wellbeing of children and young people.
- The *Domestic Violence — Identifying and Responding* document outlines the characteristics and consequences of domestic violence and identifies the role of NSW Health generally and Area Health Services (now called Local Health Districts) specifically, in recognising and responding to domestic violence. The policy provides direction on the routine screening for domestic violence program in services where significant numbers of women have been found to be at risk.
- The *NSW Health Privacy Manual for Health Information* provides operational guidance for health service staff to the legislative obligations imposed by the *Health Records and Information Privacy Act 2002.* The document outlines procedures to support compliance with the Act in any activity that involves personal health information.
- *Photo and video imaging in cases of suspected child sexual abuse, physical abuse and neglect* , provides statewide direction for on the required standards for capturing, storing and managing clinical imaging for people 0-17 years old. The policy outlines procedures to support compliance with consent, privacy, and documentation management and retention policies.
- *Subpoenas* outlines legislative provisions and procedures to be followed when the Ministry of Health and public health organisations are required to produce documents on subpoena. It includes advice on Sexual Assault Communications Privilege as the grounds for challenging a subpoena.

- *Your Health Rights and Responsibilities NSW Health* outlines how the seven basic rights summarised in the Australian Charter of Healthcare Rights are achieved in New South Wales.
- *National Framework for Protecting Australia's Children 2009-2020* is an ambitious, long-term approach to ensuring the safety and wellbeing of Australia's children and aims to deliver a substantial and sustained reduction in levels of child abuse and neglect over time. It includes high level and other supporting outcomes and actions which are being delivered through a series of three-year action plans.
- *National Plan to Reduce Violence against Women and their Children 2010-2022* brings together the efforts of the Australian state, territory and Commonwealth governments to make a real and sustained reduction in the levels of violence against women. It has six key outcomes and is being implemented through four three-year action plans.

Charters and Conventions

- The *NSW Charter of Victims Rights* aims to protect and promote the rights of people who are victims of crime. The Charter provides the guiding principles on how victims of crime should be treated by government agencies: with respect, courtesy and compassion at all times, and by having their needs as victims recognised and met during service delivery.
- The *NSW Code of Practice for the Charter of Victims Rights* stipulates responsibilities for NSW Health Sexual Assault Services in providing support and written material to non-offending family members/significant others and carers.
- The *Australian Charter of Healthcare* which includes seven basic rights of healthcare provision including: Access, Safety, Respect, Communication, Participation, Privacy, and the right to Comment.
- The *United Nations Convention on the Rights of The Child* (the Convention), was ratified by Australia in 1990.The Convention is the international instrument that incorporates the full range of human rights: civil, cultural, economic, political and social rights. The Convention recognises that people under 18 years old often need special care and protection, by virtue of the fact that they are not adults.

Appendix 5: Principles for Child Safe Organisations

Principles for Child Safe Organisations

The *National Statement of Principles for Child Safe Organisations* (the Principles) incorporate and are underpinned by the 10 Child Safe Standards identified by the Royal Commission, and are designed to be 'high level' and flexible enough to support localised implementation and recognise the range of organisational types, sizes and capacities. The Principles aim to drive implementation of child safe cultures for all sectors and within all organisations providing services to children and young people. For CPCS, child safety is core business, and it is important to remember when implementing the Principles, that new policies and practices should avoid creating undue burden on the organisation and workers which may divert resources away from serving children and young people. The Principles do not prescribe additional activities for CPCS, but provide a systematic framework to guide ways of working which prioritise children and young people's safety, wellbeing and participation.

In many ways, the Principles reflect various aspects of the CPCS framework for effective practice provided in Section 3 including, for example, an emphasis on privileging children/young people's participation and agency through authentic collaboration between CPCS counsellors, children/young people and their families; the importance of child-focused complaints processes; and of culturally safe and inclusive service provision to all children/young people, irrespective of their abilities, sex, gender, migration status, or social, economic and cultural background. Ensuring that CPCS are child safe organisations is particularly important in preventing additional systems-generated harm to vulnerable children, young people and their families.

A range of resources and practice guidance are available to support CPCS counsellors and management to implement the Principles, including but not limited to:

- Child protection training for all NSW Health employees.
- *NSW Health Code of Conduct* and *Child Related Allegations, Charges and Convictions against NSW Health Staff*.
- *The Aboriginal Child Placement Principle* (see also Section 8.1).
- *Children and Adolescents — Guidelines for Care in Acute Care Settings*.

- The NSW Office of the Children's Guardian Child Safe Organisations program of training and resources.

It is expected that all NSW Health organisations, including the CPCS, implement the National Principles for Child Safe Organisations. The Principles are:

1. Child safety and wellbeing is embedded in organisational leadership, governance and culture.
2. Children and young people are informed about their rights, participate in decisions affecting them and are taken seriously.
3. Families and communities are informed and involved in promoting child safety and wellbeing.
4. Equity is upheld and diverse needs respected in policy and practice.
5. People working with children and young people are suitable and supported to reflect child safety and wellbeing values in practice.
6. Processes for complaints and concerns are child focused.
7. Staff and volunteers are equipped with the knowledge, skills and awareness to keep children and young people safe through ongoing education and training.
8. Physical and online environments promote safety and wellbeing while minimising the opportunity for children and young people to be harmed.
9. Implementation of the national child safe principles is regularly reviewed and improved.
10. Policies and procedures document how the organisation is safe for children and young people.

Wheel of Child Safety

Implementing the Principles

The Principles for Child Safe Organisations (see Section 3.2) provide a systemic framework for organisations to address the cultural, operational and environmental risks that could increase the likelihood of abuse of children, or which inhibit detection of, and appropriate and proportionate responses to, harm to children within organisational contexts. Child Protection Counselling Services (CPCS) should consider each standard, identify related risks, and develop ways to manage or mitigate those risks.

The Principles are not intended to be followed uncritically or inflexibly by NSW Health staff, but rather are designed to be flexible enough to support local implementation across diverse service settings, while still providing clear guidance on how organisations can be child safe. Since most children participating in institutional activities or care are safe and benefit from those services, organisations need to strike a balance between 'caution and caring'. Policies must avoid creating undue burden on services which may divert resources away from serving children and young people. For these reasons, responsibility for meeting the Principles is shared across all levels of the organisation, including CPCS clinical leads and LHD divisional managers. Child safety is CPCS core business. The guidance below aims to reflect and build on effective approaches to organisational child safety within CPCSs, and to support local, context-specific, implementation of the Principles.

Child Safe Principle	Implementation guidance and practice examples
1. Child safety and wellbeing is embedded in organisational leadership, governance and culture.	Adoption of Principle 1 shows that the organisation has a commitment to child safety and wellbeing through all levels of the organisation, and that organisational leadership and governance promote an inclusive, welcoming and accountable environment and culture for children and young people. Governance arrangements are transparent and include a child safety and wellbeing policy, practice guidance, a Code of Conduct and a risk management framework. Governance arrangements vary depending on the type, nature and size of an organisation. Organisational leadership provides an authorising environment for the sharing of information about risks to children and young people. For example: • CPCS executive, management and clinical leads demonstrate through their actions and

	behaviours that CPCS core business is to empower children and young people and support their safety when accessing the service. • The service makes its commitment to chid safety explicit, for example through a public statement on its website or through visible and accessible informational posters and flyers (for example, see this hospital poster designed by children). • The risks to child safety in activities planned for in and outside the service are assessed and addressed as part of ongoing risk management strategies, and explicit provisions are made for children's safety in CPCS outreach activities (see Section 5.3.3). • CPCS counsellors provide important specialist advice and training to workers outside the service (see Section 7.1). Practice tools such as supervision meeting agendas or phone advice scripts aim to build capacity and encourage reflection on organisational safety in other services.
2. Children and young people are informed about their rights, participate in decisions affecting them and are taken seriously.	Principle 2 describes an organisational culture that supports children and young people to understand what child safety and wellbeing means. Children and young people are informed about their rights and responsibilities in an age appropriate way. They contribute and actively participate in building a safe organisational culture. For example: • Children and young people access resources that explain their rights and responsibilities when they are accessing the CPCS. • One of the approaches underpinning CPCS, client-centred practice, indicates that children are the experts in their own experiences and are often best placed to guide decisions around how to manage their own safety. Services are proactive in empowering children and young people to participate in decisions about therapeutic responses. • Children are involved in service improvement activities including monitoring and review.
3. Families and communities are informed and involved in promoting child safety and	Principle 3 emphasises the importance of involving families, caregivers and community members in an organisation's approach to child safety, including in the development and implementation of relevant policies, practices, and informational resources. This will help inform parents and carers

wellbeing.	about organisational safeguards, and encourage their feedback and input. Organisations are inseparable from their communities and both need to work together to enhance the safety of children. Due to their primary responsibility in the upbringing of children, parents, carers and families are often best placed to advise about their children's needs, capabilities and protective networks. For example: • Services engage local communities in collaborative ways to prevent child abuse from occurring. This includes being responsive to diverse needs, including building cultural safety[12] through local partnerships and respectful relationships. • CPCS work collaboratively with parents and families ensuring a trauma-informed, family and person-centred response. Interventions that improve outcomes for parents and carers improve the safety and wellbeing of children (see Appendix 7). • CPCS seek input and feedback from families and communities and provide clear and accessible information about child safety and wellbeing policies, Code of Conduct, record keeping practices and complaints and investigation processes. • Resources are available and accessible for families and diverse community members, which clearly explain their rights and responsibilities. • Materials are visible, available and accessible for families and diverse community members, which clearly explain their rights and responsibilities (for example, see the Sydney Children's Hospitals Network *Rights and Responsibilities for Families* brochures and posters).

[12] The term 'cultural safety' describes an environment "where there is no assault, challenge or denial of [a person's] identity, of who they are and what they need" and refers specifically to Aboriginal and Torres Strait Islander peoples (Williams, 1999, p. 213). This encompasses Aboriginal and Torres Strait Islander individuals' assessment of their safety and capacity to engage meaningfully, on their own terms and with a non-Indigenous person or institution. This requires action from the non-Indigenous person or institution to listen, enable and support these environments, with accountability to Aboriginal and Torres Strait Islander colleagues of service users (R. Walker, Schultz, & Sonn, 2014).

4. Equity is upheld and diverse needs respected in policy and practice.	Principle 4 considers how recognition of children and young people's diverse circumstances enables an organisation to work in a more child centred way and empowers children and young people to participate more effectively. This builds an organisational culture that acknowledges the strengths and individual characteristics of children, and embraces all children regardless of their abilities, sex, gender, or social, economic and cultural background. A welcoming organisation is one where all children and young people feel comfortable and where services are provided in culturally safe and inclusive ways. This reduces the risk of discrimination, exclusion, bullying and abuse. For example: • Addressing organisational cultural safety through implementation of audit and collaboration tools such as the *SNAICC Partnership Audit Tool*, which supports genuine interagency and community partnerships in service delivery for Aboriginal and Torres Strait Islander children and families. • Ensuring CPCS therapeutic responses for Aboriginal children and families actively consult, record and follow the guidance of those children and families, using the *Template to Record Aboriginal Cultural Consultation* (see Section 8.4) • CPCS recognise that culture is protective against harm to children and are guided by the expertise and demonstrated resilience of Aboriginal children and communities on how best to support their ongoing safety, including through trauma and racism-informed practice (see Section 8.2). One practical way that CPCS could do this is by supporting staff to comply with the *Aboriginal Child Placement Principle* (see Section 8.1). • Setting up or joining collaborative practice with other services in the local area which have particular expertise in supporting children and families with more specialist or complex needs, such as disability advocacy or settlement services (see Section 5.3).
5. People working with children and young people are suitable and supported to reflect child	Principle 5 describes recruitment and staff development policies, including appropriate screening, that are a foundation of child safe organisations. This principle also includes induction training, understanding child safety responsibilities and cultural safety concepts, and appropriate

safety and wellbeing values in practice.	supervision of staff and volunteers. Reporting obligations, training in record keeping and information-sharing provide staff and volunteers with the relevant practice tools to better safeguard children and young people. For example: • As well as conducting Working with Children Checks, services undertake screening and recruitment processes such as values-based interviewing (e.g. 'how do you relate to children?') and asking referees specifically about suitability to work with children. • Staff are made aware in an ongoing way of reporting obligations and child safety responsibilities, including through induction processes and policies, and know who to ask for help and support to meet reporting and other safety responsibilities (see Section 9). • Adequate supervision is provided to CPCS clinical staff (see Sections 10.4.2 and 10.4.5). Regular and formalised supervision is critical to mitigating risks of vicarious trauma, and to ensuring effective child safe practices, and draws on resources including the NSW Health Education and Training Institute's (HETI) *Superguide: A handbook for supervising allied health professionals*, and the *NSW Health Clinical Supervision Framework*.
6. Processes for complaints and concerns are child focused.	Principle 6 provides guidance on how human resource management policies and practices and effective complaints management processes should be accessible, responsive to and understood by children and young people, families, staff and volunteers. Complaint management processes will be linked to the Code of Conduct and provide details about where breaches of the Code have occurred. Training will help staff and volunteers to recognise and respond to neglect, grooming and other forms of harm, provide appropriate support to children and young people in these instances and meet legal requirements. This includes training to assist in responding to different types of complaints, privacy considerations, listening skills, disclosures of harm and reporting obligations. For example: • Recognising that 'child focused' complaint processes don't 'just happen' and are an

	essential component of child safe organisations. The service actively seeks children and young people's participation. Children and families are involved in the design of the complaint handling processes (see Section 10.3). • Staff have confidential ways to raise concerns, including about another staff member, where appropriate. • All complaints are taken seriously and are acted on appropriately and proportionately. • Relevant Policy Directives are followed, including the *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*; *Managing Misconduct*; *Child Related Allegations, Charges and Convictions against NSW Health Staff*, and the *NSW Health Policy on Managing Complaints and Concerns about Clinicians*.
7. Staff and volunteers are equipped with the knowledge, skills and awareness to keep children and young people safe through ongoing education and training.	Principle 7 emphasises the importance of information, ongoing education and training for staff and volunteers. Staff and volunteers build on their knowledge and skills and evidence-based practice tools through professional seminars and memberships, supervised peer discussions, team training days and access to research and publications. This ensures staff and volunteers develop awareness and insights into their attitudes towards children and young people, and have a contemporary understanding of child development, safety and wellbeing. They will be able to identify indicators of child harm, respond effectively to children and young people and their families and support their colleagues. Staff and volunteers are able to respond in culturally appropriate ways to children and young people who disclose or show signs that they are experiencing harm outside the organisation. For example: • Managers and clinical leads encourage staff engagement with relevant Policy Directives and Clinical Guidelines, including this updated CPCS guidelines. These resources provide evidence-based research synthesised to be useful for effective practice and are intended to build capacity and be educative, not simply procedural in nature. • Staff are supported to access formal training and education opportunities, for example NSW Health Education Centre Against Violence (ECAV) courses and forums, as well as the extensive training available to NSW Health Staff through NSW Health Education and

	Training (HETI). • All staff complete the *HETI Child Wellbeing and Child Protection training*.
8. Physical and online environments promote safety and wellbeing while minimising the opportunity for children and young people to be harmed.	Principle 8 highlights that reducing the risk of harm in physical and online environments is an important preventative mechanism. Risk management strategies clarify potential risks where adult to child or child to child interactions occur, or where the physical environment is unsafe. Technological platforms within organisations provide valuable tools in education, communication and help seeking. Risks associated with these platforms are minimised through all necessary means, including: education of children and young people, parents, staff and volunteers about expectations of online behaviour; the application of safety filters; and communication protocols. For example: • Precautions are taken so that an adult is not alone with a child unobserved, through for example, ensuring clear line of sight (doors are open) when children and young people are receiving therapeutic treatment alone. • Services have clear social media policies which address contact with clients online, and draw on resources such as those produced by the Office of the e-Safety Commissioner, including the *Young & Safe* resource. • When establishing or refurbishing CPCSs, children's physical safety including cultural safety is taken into account in physical and online design and children and young people are consulted. • CPCS outreach services play a critical role in ensuring equity and accessibility of the service, particularly for people living in rural and remote areas, and for families with specific cultural or confidentiality needs (see Section 5.3.3). LHDs have a responsibility to ensure child safety and CPCS counsellors' safety has been addressed and assessed in accordance with the *NSW Health Work Health and Safety: Better Practice Procedures* and *Protecting People and Property: NSW Health Policy and Standards on Security Risk Management for NSW Health Agencies*. This should include case-by-case risk assessment and mitigation processes, and implement safety precautions such as

	ensuring interpreters, cultural consultants and disability support workers are present as required.
9. Implementation of the national child safe principles is regularly reviewed and improved.	Principle 9 emphasises that child safe organisations seek to continuously improve their delivery of child safe services and their operations. They also conduct reviews to ensure that organisational policies and procedures, including record keeping practices, are being implemented by staff and volunteers. The participation and involvement of staff, volunteers, children and young people, families and community mentors in these reviews will strengthen the organisation's child safeguarding capacities. This includes the importance of reporting on the finding of reviews and sharing good practice and learnings on a regular basis. Regular reviews ensure that organisations address new challenges or concerns that arise. For example: • Building on CPCS counselling staff's existing reflective practices, CPCS managers and clinical leads support a practice culture of continuous quality improvement regarding child safety. This might include critical reflection, supervision, and active, ongoing evaluative processes. These practices inform improvements to the service as a whole (see Section 7.1 and Appendix 9). • In all review and improvement activities, children and young people are primary stakeholders and are consulted. • Complaints and near misses lead to a review of practice and corresponding updates to policies and procedures. • Audit tools for monitoring, evaluating and reviewing the implementation of Child Safe Standards are developed or sought, and used regularly, transparently and independently if required.
10. Policies and procedures document how the organisation is safe for children and young people.	Principle 10 outlines the importance of organisations having a clearly documented child safety and wellbeing policy. This will ensure all stakeholders, including organisational staff and volunteers, children and young people and their families and carers, are aware of how the

	organisation is planning to meet its obligations to create an environment that is safe for children. Partner agencies or organisations funded to provide services to children and young people should demonstrate adherence to child safety and wellbeing policies and practices. Importantly, policies and procedures do not stand in place of active child safe practices and ongoing critical reflection, monitoring and review of those practices. For example: • Local policies accurately reflect each service context and the context of the communities it serves, document how the service is child safe, and do so in easily understood language and format. • Staff are supported by clinical leads and managers to access, understand and implement the policies, and there are mechanisms for staff to seek clarity and provide feedback generated through their practice experience. • Leaders within the CPCS and Local Health Districts champion the Standards and model compliance. • Audits provide evidence of how the CPCS is child safe throughout its governance, leadership and culture.

Appendix 6: Theoretical framework underpinning CPCS practice

This appendix provides an overview of different theories used to make sense of the experiences of the children and their families and a discussion of each of these in detail. The primary purpose of this framework is to provide a shared theoretical basis that underpins and supports CPCS practice approaches.

Exploring multiple perspectives: The lens metaphor

The CPCS Framework ('the Framework') draws on a number of theories. These can be thought of like the lenses in a camera. Each lens brings part of the scene into focus, but leaves others out of view. In the same way, theoretical concepts can enhance our understanding of the different parts of a family and the surrounding system. However, in doing so they tend to bring some things into sharper focus than others. Some theories focus on immediate issues of safety for the child and for the family; some focus on the individual, such as the impact of violence, abuse and neglect on brain development; others give insight into family relationships, such as the role of a parent's attachment style on parenting; and others focus on the broader social context of gender, culture, power and class. None of these is a more or less 'accurate' picture of the family, but each provides a different insight. At all times it is essential to recognise that the picture that emerges is only as good as the lens used, and to ensure that a nuanced and multi-layered view of a family is maintained.

The Framework highlights a number of 'lenses' or broader theories that are helpful when working with families where violence, abuse or neglect has occurred. They assist the counsellor to understand the nature, causes and impact of violence, abuse and neglect, to assess risk and safety, and to plan effective interventions. The conceptual frameworks explored in this appendix include:

- The bio-ecological model of human development.
- Family systems theory.
- Child development.
- Attachment theory.
- Trauma theory.

Bio-ecological model of human development

The bio-ecological model does not determine which interventions a counsellor should use, but helps to identify at what level interventions should occur to enhance the parent and child's development. The model identifies factors that limit and enhance human development over the life course (Bronfenbrenner, 1979). It can provide a framework for understanding the many possible interconnecting factors that contribute to problems or resolutions for families.

The four central concepts in the bio-ecological model and how they relate to the CPCS are:

1. **The ecology of development:**

a. Humans develop within a nest of systems that can be likened to a set of Russian dolls. These systems are four ecological levels beginning with the micro-system, comprised of those who interact regularly with the person. These might include family members, teachers or the CPCS counsellor who sees the family regularly.

b. At the second level are the interactions and processes that occur *between* the microsystems. This might include the interactions between home and school, or the CPCS counsellor and the teacher. This is often a level at which liaison and collaboration occur to better support families, children and young people.

c. The third level does not involve the developing person directly but has an influence by impinging upon or including the immediate system. This might include the parent's work place, or how the particular CPCS works. For example, the level of support provided to a CPCS counsellor through supervision might impact on a practitioner's ability to engage a violent father; this in turn would impact the children's safety and development

d. The outer level is the macro-system, where institutions, such as government bodies and faith-based institutions are located, as well as social forces, cultural values, norms and traditions. These penetrate the layers of the system and can be deeply influential on the individual. It is not difficult, for example, to observe the way government policies that resulted in the Stolen Generations have impacted development of Aboriginal children. Similarly, racism or gender inequalities may impact negatively on development. But others may positively impact, such as promotion of high quality childcare to encourage women into the workforce.

2. The unique characteristics of the developing person:

a. Every person has his or her own unique biology, psychology and behaviour (often referred to as 'bio-psycho-social characteristics'). These characteristics can elicit positive interactions from others that promote development, or may impact negatively on development. Application of the bio-psycho-social approach is seen as part of the theory of change underlying CPCS practice. It helps to consider potential ways in which different family members including the child/young person are impacted in a biological, psychological and social way and how interventions need to target each of these areas

b. Different characteristics can invite or discourage responses from others that promote development. Examples of characteristics that promote development include social responsiveness, friendliness, exploratory behaviours, the ability to manage emotions, or the ability to defer gratification. It is easy to see how these might elicit responses from others that help development. On the other hand, examples that would be disruptive of development might be characteristics such as hyperactivity, poor impulse control, cognitive problems or aggression. These may get in the way of others in the microsystem providing the kind of interactions that would maximise developmental opportunities

c. The model emphasises that others in the system surrounding the child/young person also have their own bio-psycho-social characteristics and these interact

together to influence development in a reciprocal way. For example, a child who is unsettled and crying might elicit extra care and nurturance from a confident and stable parent. But if the parent is overwhelmed or depressed, the same child may elicit a very different response. It is not difficult to see how the parent and child might influence each other's wellbeing and development in a recursive way.

3. **Proximal processes: the 'building blocks of development':**

    a. The repeated interactions between the person and those in their microsystem are the building blocks of development. These are called the 'proximal processes' and as illustrated in the examples above, are the primary mechanisms of development. Bronfenbrenner (1979) called them 'the centre of gravity'

    b. Certain characteristics like cognitive capacities are not just outcomes of development but are also 'precursors' and 'producers' of development. That is, certain individual characteristics can influence the responses of others (the proximal processes) that are the building blocks of development and in a recursive way, impact on development itself

    c. In CPCS interventions, it is often the quality of proximal processes that needs to be enhanced, but the intervention may or may not be directed at the caregiving behaviours themselves. For example, providing support to parents/carers to deal with the stresses in their lives can improve their ability to regulate their own distress, and respond in an attuned way to their child; other parents/carers may need guidance on child development so they can better consider and meet their child's needs; and another parent, who may be triggered by his or her own trauma when the child reaches a certain age, would benefit from trauma-focused therapy. Each of these are different ways of intervening to enhance proximal processes, without directly intervening in the care taking behaviours themselves.

4. **Time:**

    a. The notion of time is important at every level of the system — historical time, biological age/stage, family history, past, present and future

    b. At the micro level it starts with the small, immediate individual episodes of interaction (or proximal processes); and at the macro level involves changes over generations and the life course

    c. Time as a context for development has been called the 'chronosystem', represented as a fifth layer surrounding the developing person.

These examples demonstrate that a child/young person's development occurs in interaction with the adults who care for him or her. The child/young person both elicits and responds to the nature of care provided, dependent on a range of factors that exist within each individual. However, the individual characteristics do not exist in a vacuum, and the parents/carers' response to the child/young person is influenced by the interplay of their own bio-psycho-social characteristics. Therefore, the environment could either optimise or interfere with the proximal processes. For example, changes to workplaces,

family structures, community structures and systems, childcare and neighbourhoods can have critical effects on the nature and quality of the care provided to the developing child and impact directly on aspects of development. It is important to note that the bio-ecological model does not assume an inevitable or direct cause between individual characteristics and the developmental outcome; rather it emphasises the 'potential' relevance of factors.

Although the examples above focus on children and young people, the concepts are applicable to human development across the life course. Whatever the life stage or historical moment, the bio-ecological model identifies the range of influences on the proximal processes and through them, on development. For example, consider the developmental impact for an older person who is suddenly caring for their grandchildren in a kinship care placement. This could impact on the grandparent's healthy development and social life in a variety of ways that may then impact on their ability to care for the child.

Over time the model has been affirmed and enriched by knowledge from other areas. For example, the concepts of attachment and trauma illustrate the way that a child/young person's environment, especially interactions between parent and child, influence the child's development. The pattern of caregiving between a parent and child (proximal processes) eventually evolves into a developmental outcome for the child/young person called the attachment style. The attachment style will in turn impact on ongoing developmental experiences. The model would also consider how a childhood experience of neglect or abuse could be expressed across the lifespan, including how they then parent their own children.

A bio-ecological approach provides a framework for understanding the importance of not only what happens in a therapy room, but why the role of the CPCS counsellor can also be about how to help others in the child/young person's world interact in a therapeutic way. In other words, it is not just about the type of therapy, but creating a therapeutic world (Frederico et al., 2010). This illustrates why it is important for CPCS counsellors to not only provide counselling and other therapeutic interventions but also provide system intervention. This can involve psychoeducation with the family, carers, the school or others, advocacy, and enabling the system to respond to the child/young person's needs in an attuned and respectful way.

Applying the bio-ecological model to a case example

This case example applies the bio-ecological perspective to consider the influences on the development of Hugo, aged 14 months, and Mia, aged four. They currently live with their mother, Rachel, and grandparents Leanne and Howard. Their father, Teo has weekly supervised contact due to recent and long-term family violence. Teo is Aboriginal and has had little contact with his own family since he left home at the age of 17.

It is clear that the children's development has been impacted by their parents' substance use and their father's violence. However, the way each child has been impacted varies according to their temperament, gender, age, the presence of

other supports and their parents' functioning.

From a very young age both children were exposed to a lot of violence and drug use in the home. When Rachel was not anxious or affected by marijuana she was affectionate and provided adequate care to Hugo and Mia. When both parents were drug-affected life was chaotic and unpredictable. Their mother would often sleep through meal times and not hear Hugo if he woke at night. When she had money, Rachel enjoyed buying toys for the children, but these were often not at an appropriate for their age and needed an older child or adult to operate them.

Teo was like 'Jekyll and Hyde'. When he was not substance-affected he played physical games with Hugo, throwing him in the air, and tickling him. He had less time for Mia whom he said was 'spoiled' and 'naughty'. He was often angry and substance affected and at these times Rachel would try to keep the children quiet and make sure they were not in his way. The violence was directed toward Rachel whom he accused of having affairs or not caring about him. At 14 months Hugo is an attractive little boy with big brown eyes. He learned very quickly that it was safer to be quiet and not to demand attention. He is seen as 'easygoing' because he usually sits quietly in his cot. He slept through the night from a very young age.

Hugo has spent a lot of time in the cot and constantly sucks a dummy. He has little opportunity to play on the floor, or to experience new things in a safe way. He frequently sits in front of the tv in his cot to keep him amused. As a result he is delayed in several areas of his development. Although workers find him appealing and quickly become fond of him, he rarely cries or seeks comfort when he is hurt or upset. However, he happily goes to any adults who approach his cot and offer to pick him up.

Mia is seen as much more demanding. She wets the bed and is often tearful if frustrated or upset. She is very clingy to her mother and is very shy with adults who visit even if she has met them before. She often asks her mother to play with her and does not enjoy playing with other children. At four years of age she had not attended preschool or childcare until the family recently moved in with their grandparents.

If we consider the children in their current circumstances we can begin to see the way changes in their microsystem directly impacts on the proximal processes that lead to significant changes in the children's development. These changes in proximal processes occur due to a cessation of the violence, for example:

- Rachel gaining more control over her drug use and an increase in the supports available to Rachel.
- Teo's contact with the children is supervised and he is beginning to deal with his violence and the impact of his own childhood trauma. However, some issues in the extended family remain. Leanne and Howard are supportive of Rachel but would like her to have no contact with Teo.
- Howard has struggled with depression off and on and often feels the stress

of Rachel's problems has taken its toll in his own health.

- Since Hugo moved in with his grandparents his daily life has changed. He no longer spends hours at a time in the cot and his grandmother plays with him regularly.
- Rachel has developed a relationship with a worker who helps her understand the children's behaviour and their needs. As Rachel has begun to trust the worker she has disclosed her history of sexual abuse and told her parents what happened to her. Her parents have been very distressed by the disclosure but are now more understanding of why she 'went off the rails'. They are now less blaming of her and want to support her in recovering from her trauma. Rather than being critical of her when she is not coping with the children, Leanne and Howard now offer to help when they can see she is struggling.
- The worker has been working directly with Rachel and Mia to help recover from the violence. She has helped Rachel and her parents understand that Mia is not being naughty, but is fearful and needs to feel safe. They now spend more time comforting her and playing with her, rather than being impatient of her clingy behaviour.
- The work with Rachel and her parents has been making sense of the shared history of pain and misunderstanding that has resulted from the recent years of Rachel's drug use. Rachel's parents are finding it difficult to trust her and fear she will relapse into drug use; she often feels like they don't appreciate how far she has come in her recovery.
- Teo has been attending the men's behaviour change program and is regularly playing in his Aboriginal football team. He has become interested in tracing his own family history but is not ready to do this yet. He enjoys seeing the children but is upset that Mia doesn't want to go to him on contact visits. Mia often asks anxiously about when she can go home to mummy. He still gives most attention to Hugo, but with the guidance of the person supervising contact he has begun to use toys and books to engage Mia in play. The CPCS counsellor has been helping Teo understand the impact of the violence on the children and on Rachel. She has also been talking to him about Rachel's parents and their anger at him for the violence. They are still very suspicious of his motives, and the worker has been helping Teo to understand their position and consider how he could demonstrate that he is trying to do things differently.

As we go out through the systems surrounding the family we can see that changes at the outer levels have impacts and consequences for different family members and will impact on how they interact with the children. Howard's depression is an example of the way changes at different levels of the system can impact on the proximal processes that constitute the children's daily care.

- The impending loss of Howard's job has made him more depressed. Leanne feels divided between supporting him and supporting Rachel and the children. She wants Rachel and the children to stay with them as long as

they need to, but with her own job under threat she is worried about how they will all survive financially. She is worried she may have to find other work, which will mean that she won't be able to help Rachel with the children.

- Rachel feels upset when her father is depressed because she feels like a burden to her parents. It also reminds her of her own childhood and all the years she used to go to her Nan. She still misses her Nan and feels she did not get a chance to grieve because of the sexual abuse that began around the time Nan died. As her feelings become more painful Rachel is tempted to use drugs again. When she feels like this she finds herself more impatient with Mia and more likely to leave Hugo to his own devices.
- Howard has always felt very guilty about his depression and reluctant to seek help outside the family. However, he recently heard something on the radio about a group for men with depression. He is thinking of finding out more about it but doesn't know where to start. He has never met other men with the same problem and was surprised to hear it is common. The local community health centre recently received funding to participate in some research with Beyond Blue. They are investigating the role of group treatment programs for men with depression. They have begun a community education campaign to raise awareness and recruit participants.

Family (and surrounding) systems theory

The inclusion of families in counselling and other interventions is an essential part of CPCS practice. It is also important to consider how families and other levels of the surrounding systems interact together. Concepts from family systems theories can assist in understanding the interactions within the family, between the family and other levels of the system, and even between individuals within the broader system such as organisations and services in the ecosystem.

To meet children and young people's needs, individuals and families change and develop across the life course, systems theories highlight the way families develop over time to be both stable and adaptable to new circumstances. Important concepts relating to families include (Goding, 1992):

1. **The family as a system**

   a. A family system is not just a collection of individuals. A system consists of the members of the system, as well as the relationships between them. That is, 'the whole is greater than the sum of its parts'.

   b. Behaviour in a family or other social system is influenced by the characteristics of the individuals, the relationships and interactions between them and the context around them.

   c. This does not mean that the whole is more important than or superior to the individual, or that everyone in the system has equal ability to influence outcomes.

2. **Change and stability**

   a. As they change and interact, individuals and the family as a whole recursively influence each other.

   b. For a family to continue to develop it must evolve to meet the demands of its changing members and context.

   c. Stressors, events and interactions with their world can affect the family's stability and growth. These could include events from outside (such as unemployment) or from inside the family (such as a birth or death).

   d. Stressors and their impact on individuals and the family can be ordinary, normative events, as well as extraordinary ones; even positive events, such as a new baby arriving or moving to a bigger home, can be stressful.

   e. Family Life Cycle is a useful model to understand transitions as the family evolves and adjusts to the challenges of time and context (Carter & McGoldrick, 2005).

3. **Circularity: Patterns of interaction**

   a. Systems 'self-regulate' via processes of communication called feedback loops. A feedback loop is simply a response to a new behaviour or information in the system. Some feedback loops lead to change, some maintain stability.

   b. Patterns of interaction (or dynamics) form over time and tend to be repetitive and stable. Changes in an individual can lead to changes in the interactional patterns; and changes in interactional patterns can lead to changes in the individual members.

   c. Patterns of interaction tend to be repeated in a circular way. Where it begins and where it ends is a matter of punctuation. This leads to the idea of 'circular causality' (A leads to B leads to C leads to A) rather than linear causality (A causes B).

4. **Structure: hierarchy, subsystems and boundaries**

   a. All systems have a structure that includes a hierarchy, subsystems made up of individuals or groups within the system, and boundaries between subsystems and with the outside world.

   b. Systems also have their own rules which determine how people interact and with whom. These rules are usually visible in the patterns of interaction, the subsystems and the boundaries.

   c. Smaller systems (like families) interact with the larger system, rather than being acted upon by the larger system. The structure and characteristics of the family system are not caused by the outside world, but form in interaction with it.

5. **Communication: meaning, behaviour, context**

a. Communication is not just about language. 'All behaviour is communication. It is impossible not to communicate' (Watzlawic, Beavin-Bavelas, & Jackson, 1967).

b. There are four elements that affect the meaning of a communication — the message, the sender, the receiver and the context. Meaning is subject to interpretation or construction by the receiver interacting with the environment.

c. There are also multiple levels to communication. Meta communication refers to communication about the communication. For example, the same words can have very different meaning depending on context, history, tone, and other nonverbal cues.

6. Constraints to change

a. Times of developmental change are particularly challenging for families and other systems as they are required to adjust and evolve to new demands. Many systems 'get stuck' at such points of change.

b. Common constraints to change are beliefs, the meaning of behaviour, stuck patterns of interaction, broader system barriers like resources, or structure that is ineffectual or inappropriate.

When a family is understood as an interacting system, it is clear that an individual child/young person or adult cannot be fully understood without understanding the family context surrounding them.

It is also important to remember that when CPCS counsellors observe and interact with families, they are seeing them in a particular context; one that includes the counsellor in the role of both participant and observer. As CPCS counsellors engage with families they become part of a shared system. This extends into the broader system of CPCS and the other services. The concepts above can also be helpful in understanding the interaction between counsellor and family, and within and between the broader system. For example, a common stuck pattern of interaction between a family and counsellor occurs when crises become the focus of attention, rather than the underlying issues the family need to deal with. Or a sense of hopelessness could pervade the family and the helping system, as everyone becomes more and more paralysed by the problems that confront them. Supervision and reflection can help unstick these patterns by noticing them and taking steps to change the interactions.

Table 6 summarises some useful lenses for observing and thinking about a family. Multiple lenses will usually be needed to achieve a complex and informed understanding of the family. These lenses can be shared with the family and guide inquiry with them.

Table 6 Useful conceptual lenses to understand families (Dwyer, 2007)
Patterns • All families have repeating patterns of interaction, often called family dynamics. These are necessary for predictability and stability • Some patterns of interaction may help maintain a problem, even if they didn't cause it in the first place — in family therapy it is often noted that the solution can become the problem • Patterns may be in the short term (minutes or hours), intermediate or long term • They can even occur across family generations • May be evident in the roles, beliefs, experiences, myths.
Structure • Refers to the way in which power and authority are expressed and negotiated • Who is in charge? Who is aligned with whom, and what kind of relationship do people have? • Boundaries — within the family, and between the family and outside world • Alliances and coalitions.
Meaning • People respond to situations and events according to the meaning they ascribe to it e.g. a parent responds differently to a crying child if they think the child is tired or being naughty • If meaning changes, people often change behaviour • Events don't have the same meaning for everyone. Meaning can be determined by many factors — age, previous experience, culture, context, values • Meaning can be 'reframed' • Some meanings are unconscious or beneath awareness. After trauma, the brain may automatically associate certain stimuli with the previous trauma — thereby creating a trauma fuelled 'meaning'.
Transgenerational • Experiences within the family of origin are central influences on individuals at multiple levels — including attachment, roles, values, beliefs, parenting • These make their way down through generations as repeating patterns • They include both strengths and challenges.
Developmental Framework • A developmental lens looks at both individual and family development • What are the individual and collective developmental experiences? • How do the different stages of individual development impact collectively on the family unit — what are the demands and tasks of these stages? • Families may be at multiple stages at the one time — and all requiring different tasks e.g. there may be teenagers from one relationship and a newborn from another; grandparents may be required to care for young children • What are the stressors associated with these developmental stages and tasks? • The role of vertical and horizontal stressors — associated with systemic, transgenerational and developmental stages (Carter & McGoldrick, 2005).
Other lenses, not derived from family therapy, MUST also be included. Some of these include: • Power and power differential • Gender • Culture • Attachment • Trauma • Class • It is also essential to keep in mind: who is choosing and using the lens? That is, what does the therapist bring and how does this contribute to the picture that emerges.

When the client system and the organisational systems start to mirror each other

There is a phenomenon often observed in systems whereby relationship dynamics in one system begin to be reflected in another system that interacts closely with it. For example, a team working with families who are often in chaos may find that their own processes also become chaotic; a care team may find that despite a number of people involved, no one seems to be case-managing a family where neglect is an issue, or the workers involved with a family violence matter may feel constantly bullied by others in the system.

There are two concepts that assist in understanding these processes; the first is the psychoanalytic concept of parallel process, the second comes from biological sciences and is called isomorphism.

1. ***Parallel process***: Refers to relationship dynamics and emotions that can be transferred unconsciously between levels of the system. It is often used to understand relationship patterns between a therapist and client that are transferred to the relationship between the therapist and supervisor. The client's unresolved issues are re-enacted with the therapist in a process of transference; the therapist takes the transference into the relationship with the supervisor and unconsciously enacts the same dynamics. When recognised, the supervisor can assist the supervisee to resolve the issue in a way that is then taken back to the relationship with the client.
2. ***Isomorphism***: When systems are connected they influence each other and therefore have the potential for isomorphy; that is, to develop a similar structure. In family therapy the concept sometimes refers to the need for individuals within a family to differentiate — to be both connected and separate.

Systems can begin to mirror the structure and relationship dynamics of the other. While vastly different in aetiology, each of the theories above recognises that the influence between the systems is two-way. That is, if the family or client can influence the worker and organisation, then the worker and organisation can influence the family and client. Some theorists see these processes as inevitable and harnessing the opportunity that comes with them as an important source of influence and change.

CPCS frequently interacts and engages with other systems and as such, the opportunity (or risk) of isomorphism or parallel processes exists. It is important to be mindful that powerful or dominant dynamics within one system will make their way into the other unless they are consciously noted and guarded against. The following are some common examples of the way these processes can be transformed by harnessing the dynamic and influencing the system toward positive change:

- When working with clients and services that may be chaotic, it is important to ensure planned and structured processes such as regular meetings, following through on decisions, and planning ahead
- When secrets, coercion or disempowerment are problematic themes, actively ensure transparency, openness and appropriate use of authority
- Supervision, consultation and critical reflection can all assist in guarding against parallel isomorphic processes

Child development theories

The bio-ecological model of human development highlights that development does not just occur in childhood, but continues throughout the lifecycle. Understanding child development is an essential element to understanding and working effectively with infants, children and adolescents.

Age is an imprecise marker of development, particularly for children/young people who have suffered complex trauma, but it is the primary one available (Jackson et al., 2013). Children and young people's physical, cognitive, psychological and other areas of development occur through a complex cascading process, whereby all aspects of development are interacting and mutually influencing each other (Tronick, 1989). They are born with certain biological systems, but the way these develop is in interaction with the environment, including experiences of trauma and the nature and quality of care and relationships provided.

CPCS may see families where there are several children/young people in the sibling group. These may be at very different stages of development and be differently impacted by the circumstances of their daily lives. Children/young people in one family may also have different mothers or fathers, which can influence genetics, culture, parenting experiences and needs. It is important that CPCS counsellor's consider the developmental needs of each child/young person and how these interact together. It is also important to consider how the experience of the children/young people has impacted on their sibling relationship. For example, one sibling may take on a parental role, others may compete for the scarce resource of parental attention, and others might comfort and support each other during difficult times.

Thinking developmentally about each child/young person referred to CPCS can involve a series of questions including (but not limited to):

- What is the child/young person's current stage of development — both challenges and resources, given the child/young person's age and context?
- What are the characteristics of the child/young person (gender, abilities/disabilities, temperament, behaviours) that are likely to enhance or impinge on the quality of care she/he receives?
- What is the history of trauma experienced by the child/young person, from in-utero to current time; and how do the child/young person's symptoms reflect the developmental impact of those traumas? What is the nature of the care the child/young person has been provided with, and have there been disruptions to important caregiving relationships?
- What are the developmental skills and capacities required by the child/young person at this age, e.g. being attached to adults, participating in school, learning and social interactions? What are the child/young person's strengths?
- How can the child/young person and family be supported to support and enhance the building blocks of development?

- What are the cultural implications, resources, and needs when exploring these questions for Aboriginal children, young people and families? For children and young people from other CALD communities?
- Is specialist assessment of aspects of the child/young person's development required?
- How has the experiences impacted the development of their sibling relationships?

A healthy and positive childhood equips children and young people to meet a vast array of expectations and challenges, even if they don't succeed in every situation. A neurodevelopmental lens helps practitioners to understand some of the complexities of childhood and to make sense of what happens when the childhood is experienced as one of violence and deprivation. In the remainder of the document, child development is considered through the lens of attachment and trauma.

Attachment theory

Attachment theory was first developed by Bowlby (Bowlby, 1973, 1980, 1988) and Ainsworth (1967), and focused on the interaction between infant and caregiver. They recognised that infants are born wired to attach to caregivers to ensure their survival. Survival and optimal development requires that the caregiver stays in close proximity to protect and nurture, but also that the child/young person is able to explore and learn. At each stage of development the caregiver provides the 'secure base' from which the child/young person explores the world and returns for comfort and care. This process of proximity seeking and exploration is evident in the child/young person's attachment behaviours.

> Faced with danger, the infant will seek safety
> Faced with distress, they will seek comfort
> Faced with isolation, they will seek proximity to their attachment figure
> Faced with chaos, they will seek predictability (Baim & Morrison, 2011, p. 14).

Three attachment tasks are required of parents and carers:

- To protect and comfort the child when the child cannot do it for him or herself;
- To guide the child to protect and comfort him or herself; and
- To let the child take developmentally appropriate responsibility for him or herself (Crittenden, 2008).

This interactions between caregiver and child/young person begins from birth; an infant's signals when in need of comfort or care, such as crying, smiling, or clinging invite responses from the caregiver. The pattern of caregiving behaviours, or the way the parents and carers respond to the child/young person's needs for closeness and comfort, in turn contributes to the behaviours by the infant.

These attachment behaviours may appear differently from one culture to another and at different ages over time, but they share the common function of keeping humans connected to others (Jackson et al., 2013). Caregiving behaviours also frequently differ

across cultures although they share the function of keeping children safe and encouraging their development (Ryan, 2011; Yeo, 2003).

Bowlby noted three phases of response when young children are separated from parents or caregivers — protest, despair and detachment. Children initially protest the separation by crying or showing distress; if not successful the child then shows despair by withdrawing; the final phase is detachment, where the child is blank and shows no emotion (Bowlby, 1980). A child's attachment style is assessed by a structured observation of the responses of children to separation and reunion with the primary caregiver. Children fall into one of four categories of childhood attachment: Secure, Insecure (avoidant), Insecure (anxious/ambivalent), or Insecure (disorganised/disoriented).

An adult's own attachment experience is important in the way that they then respond to their child's attachment needs. Adult attachment styles can influence the parent's availability and responsiveness to children. This is an important focus for counselling, because of its critical impact on the developing child. Although enduring, an adult's internal working model can change with support, new relationships and/or therapy. The four adult attachment styles (Main, Kaplan, & Cassidy, 1985) are: *Autonomous (secure), Dismissive (detached), Preoccupied (entangled), Unresolved (disorganised).*
Table 7 shows the four attachment styles for children and how these translate to adult attachment (Jackson, McConachy, & Bartlett, 2014, p. 40).

Table 7 Child and adult attachment styles

Child attachment styles (Kobak & Madsen, 2008)			Adult attachment styles (Bretherton & Munholland, 2008)		
Organised	Secure attachment	Child has confident expectations of carer as both safe haven and secure base and has strategies to elicit the carer's responses	Resolved	Autonomous	Adult is able to give coherent, emotionally open accounts of childhood attachments
	Insecure avoidant	Child is less confident of carer as safe haven. Expects rejection when distressed and has strategies which include avoiding getting too close		Dismissing	Adult avoids questions about childhood and less able to speak about or with emotion
	Insecure ambivalent (or resistant)	Child is less confident of carer as a secure base. Expects rejection or not to be a priority when separate from carer. Has strategies which include staying close and clingy to carer but being angry when they are close		Pre-occupied	Adult speaks of many conflictual or angry attachment memories, with some positive. Loses track of questions and avoids deep reflection on childhood. More likely to be lost in emotion of the past

Disorganised	Dis-organised	When child's source of danger is also source of supposed safety (e.g. attachment figure has abused child) then child has no consistent strategies and can be angry, distant, clingy.	Unresolved	Unresolved	Adult cannot speak coherently about the past

No parent can be attuned every minute. Indeed being 'out of sync' with a child/young person and then repairing the rupture is an essential part of the development of secure attachment (Tronick, 1989). The process of repair offers opportunities for development, learning, healing and recovery (Siegel, 2012). The experience of brief ruptures in the parent-child interaction when followed by a successful repair can help build the child's capacity to not be overwhelmed by the normal stresses that can occur in relationships (Tronick, 1989). Although ruptures and repairs are found in healthy parent-child relationships, research has shown that high-risk parents may initiate more ruptures and have less capacity to undertake the repair. This can point to a useful target for therapeutic intervention (Skowron, Kozlowski, & Pincus, 2010).

Attachment styles can change over time and through experiences, but early attachment experiences are foundational. At any age, a person's level of confidence in self and others (i.e. internal working model), his or her ability to rely on others to provide a safe haven when distressed and a secure base when there is a need to be brave are all hallmarks of the attachment style (Jackson et al., 2013).

Research has shown that children's attachment style can be influenced by their caregiver's adult attachment style and this is independent of the impacts of past abuse and neglect (Dozier, Stoval, Albus, & Bates, 2001). When necessary, interventions should focus on helping the parent/carer to develop a coherent perspective of their past and increase their sensitivity to the child's cues (Dozier et al., 2001).

Like all theoretical concepts, the interpretation of attachment theory has been influenced by broader social values and beliefs, and the state of knowledge at the time. Our knowledge of children's developmental needs has grown since Bowlby first developed his theory. For example, there is evidence that in the right circumstances, children and young people can reorganise their attachment patterns around the availability of a new caregiver (Pace & Zavattini, 2011). This has become increasingly recognised over the past 20 years, such as through the research conducted in relation to children adopted from Eastern European orphanages (Rutter, 1998; Zeanah, Smyke, Koga, Carlson, & Bucharest Early Intervention Project Core Group, 2005). It has also been increasingly understood that caregivers can assist children to change their attachment behaviours, including signalling their needs for care and comfort.

Attachment and Aboriginal culture

Attachment theory first developed as a Western concept. It is relevant to human development across cultures, however, there are cultural differences in how attachment

is expressed through behaviours (Bamblett et al., 2012). 'Although attachment behaviours are found across all cultures, they are interpreted within a cultural context and can be misinterpreted if the cultural context is misunderstood' (Jackson et al., 2013).

Applying attachment theory with Aboriginal children/young people requires an understanding of Aboriginal parenting practices and exploring concepts of attachment security through connections to extended family, clans, and kinship systems rather than simply the dyadic mother-child relationship (Neckoway, Brownlee, & Castellan, 2007).

In Aboriginal culture child rearing is usually done by the family and community and not confined to the child/young person's parents. The child/young person's secure attachment base is usually to a network of attachment figures rather than one or two people (Coade et al., 2008).

Attachment may also be a useful concept to understand aspects of Aboriginal people's connection to country.

> 'It is possible to extend the metaphor associated with attachment theory of needing a safe haven and a secure base to describe some aspects of Aboriginal people's connection to the land, such as the pull to return to their country when dealing with loss and needing comfort'. (Jackson et al., 2013)

In Aboriginal culture, exploration away from a parent followed by reunion may present differently from many Western cultures (Yeo, 2003). Yeo reported that Aboriginal parents were more likely to anticipate their children's needs through frequently checking on them, rather than waiting to respond to the child/young person's distress. This could be misunderstood as the parent being overly clingy or under-responsive, whereas neither may be the case.

A false dichotomy that often arises from misunderstanding the crucial nature of Aboriginal culture and children/young people's attachment to others is thinking that one has to choose between them. An Aboriginal child's need for connection and belonging to culture and community are not dissoluble from their need for connection and belonging to attachment figures or an attachment network.

Alf Bamblett, an Aboriginal Elder once stated, '…culture is to people as water is to fish' (Bamblett, cited in Victorian Aboriginal Child Care Agency (VACCA), 2008, p. 11). Hardy (2009) demonstrated that an infant's needs may be met through patterns of attachment behaviours that differ across cultural and environmental contexts. Rather than attachment being in opposition to culture, it is important to understand how attachment may be expressed within different cultures.

Attachment-informed interventions

There are a growing number of evidence-informed interventions that promote attachment. These have been designed for children/young people in out-of-home care, as well as those reuniting with parents or in the care of their parents. They are targeted at specific groups such as mothers and children after family violence, young mothers, fathers, and

so on. A small number of internationally recognised programs are noted here as examples, but practitioners and counsellors are encouraged to locate local attachment based programs in their communities.

Dozier and team developed a model to promote secure attachment for young children in foster care (Dozier et al., 2006). They reported four key messages that informed the Attachment Behavioral Catchup (ABC) model:

1. Children/young people who have experienced abuse or neglect are at high risk of emotional, behavioural and physical dysregulation. As such, the target of intervention is to increase the parent or carer's understanding of the child/young person's dysregulation as well as their own, and to help them understand the implications of this dysregulation on the child/young person's behaviour, development and physical health.
2. All children/young people need co-regulation through an attuned adult before they can self-regulate. As such, the target of intervention is to help the adult to self-regulate their own physical and emotional regulation in order to co-regulate the child/young person.
3. Children/young people who have experienced disrupted attachments often do not give signals to parents or carers that elicit nurture. Instead these children/young people may push adults away. As such, a target of intervention with parents and carers is to help them develop ways of nurturing the child/young person even when they are trying to push them away and to understand the meanings behind the child/young person's behaviour.
4. Parents and carers may have their own difficulties which could interfere with their caregiving behaviours and capacity to be nurturing to the child/young person, especially when under duress. As such, a target of intervention is to help parents and carers understand their own reactions to the child/young person and to stress and how to modify these in response to the child/young person's behaviours. (Dozier et al., 2006).

Other attachment-informed approaches which emphasise educating parents or carers on key attachment principles include the *Circle of Security* (Marvin, Cooper, Hoffman, & Powell, 2002) and the *Secure Base* model (Schofield & Beek, 2014). These psycho-education models are focused on helping the parent or carer's responses to children/young people with an insecure or disorganised attachment style. They share the goal of helping children/young people develop more secure attachment styles when they develop greater confidence in their parent or carers' ability to be a safe haven and secure base. Circle of Security encourages parents and carers to consider the balance of encouraging autonomy and exploration with the need for care and control. 'Always be bigger, stronger, wiser and kind. Whenever possible follow my child's need. Whenever necessary, take charge' (Marvin et al., 2002, p. 109).

Schofield and Beek (2014) discuss five elements to promote:

- the child/young person's trust in the parent/carer's availability;
- the child/young person's reflective function (ability to think about his or her own mind and the minds of others) which is a function of intersubjectivity;

- the child/young person's self-esteem;
- the child/young person's autonomy; and
- family membership (security that comes from a sense of identity and belonging).

These approaches employ an understanding of the adult attachment style to identify potential barriers or difficulties that the adults need to resolve so as to be more responsive and available to the child/young person.

Hughes's Dyadic Developmental Psychotherapy (DDP) approach is informed by the work of Dozier, Siegel and Schore as well as Hughes's approach of PACE (Playfulness, Acceptance, Curiosity and Empathy). DDP aims to help parents and carers respond in a tailored way to the child/young person's attachment style and needs.

Trauma theory

CPCS is a trauma-informed and trauma-specific service. An understanding of trauma theories is essential to understand the impact of abuse, neglect, disrupted attachment and exposure to domestic violence on the child or young person. It also equips practitioners to recognise the signs of the impacts of trauma, conceptualise the treatment and intervention plans and facilitate referrals and interventions as early as possible. In addition it limits the likelihood of re-traumatising children, young people or other family members and can also help guide practice to avoid secondary trauma where possible.

Trauma, stress and threat

Trauma needs to be differentiated from stress that is experienced as a normative part of development. Stress is not always harmful but is a key part of child and young people's development and building resilience (Perry, 2006). 'The ability to cope with novel and/or potentially threatening situations, such as an unfamiliar environment or physical danger is essential to survival' (National Scientific Council on the Developing Child, 2005, p. 1).

It is helpful to distinguish between positive stress, tolerable stress and toxic stress:

- ***Positive stress*** involves moderate, short-lived stress responses, is a normal part of life and an essential feature of healthy development
- ***Tolerable stress*** involves stress responses that may affect brain structures, but usually occur for brief periods that provide time for the brain to recover and reverse potentially harmful effects
- ***Toxic stress*** involves strong, frequent or prolonged activation of the body's stress systems which can lead to adverse impacts on brain structures and change the stress system, so the person responds at lower thresholds to events that might not otherwise be considered stressful (National Scientific Council on the Developing Child, 2005).

The term 'resilience' refers to the individual or community's ability to buffer the consequences of trauma or other types of adversity. This is influenced by a variety of factors, including early life experiences, attachment relationships, the presence of social

supports and genetics. In contrast, overwhelming, unpredictable and intense stresses can be traumatic.

Perry developed the concept of the stress arousal continuum to reflect different responses that can occur after a traumatic event. When a traumatic event occurs, the average person can move up the stress arousal continuum from calm — alert — alarm — fear — terror (Perry, 2003). Factors that influence the responses include the individual's vulnerability or resilience prior to the event, and access to supports. Toxic stress or trauma overwhelms the individual's internal and external resources and if it continues, can diminish their capacity to cope in the future (Van der Kolk, 1996). Children, young people and adults who have been exposed to multiple traumas over a period of time may be in a constant or frequently high arousal state or a dissociative state where they are disconnected from their feelings (Herman, 1997).

Developmental aspects to trauma

A person's age when exposed to trauma is as important when considering the possible consequences. When an adult with an already developed and organised brain is exposed to major trauma, they may be dysregulated to the extent where it impacts on their daily functioning. When this event involves an infant child or young person whose brain is in the process of developing and being organised, it can impact on their current functioning, but also on how their brain continues to organise and develop. Trauma, especially chronic trauma, can alter a child/young person's developmental trajectory.

Childhood is characterised by different windows of sensitivity. The most documented period of sensitivity is the first three years of life (Fox et al., 2015). This period is unparalleled in the extent of changes that occur as the child or young person's brain is laying down the foundational networks that will be there throughout their life. This window enables the brain to change in response to experiences that enables the child or young person to develop, grow and learn. It is when these experiences are traumatic and dysregulating, that this sensitivity can place future development in jeopardy (Van der Kolk, 1996). The capacity for change is not limited to the early years, and continues throughout childhood and even adulthood. One of the other most marked periods of change is early adolescence through to young adulthood. An increase in myelination, synaptic connections and dopamine levels are just some of the changes observed in brain development during adolescence (Fox et al., 2015; Steinberg, 2009).

There are multiple areas and networks in the brain and body that are organised to perceive and react to threat as efficiently as possible. When the threat is real and requires a physiological response, these networks are very adaptive and purposeful. When the threat is time-limited and in the context of an otherwise typical life of highs and lows, the individual's threat response will usually return to their pre-threat state. However, when the threat is overwhelming, ongoing or unpredictable and particularly when interpersonal (such as abuse and neglect), the person's threat response and the physiological markers may lead to longer term changes in the brain.

Neuroscience suggests that stressors and trauma are mediated through different areas of the brain (e.g. Anda et al., 2006; Hull, 2002; Van der Kolk, 1996). There are also studies

that demonstrate the impact of neglect on the brain (e.g. De Bellis, 2005; Perry, 2002; Perry, Colwell, & Schick, 2002).

The effects of trauma

The effects of trauma and other pervasive adversity can be wide-ranging and have a high impact. These impacts can include:

- Hyperarousal and difficulty in regulating arousal (e.g. fight and/or flight response).
- Dissociation.
- Problems with information processing and working memory.
- Hypervigilance.
- Problems with attention and concentration.
- Fear response to trauma-related stimuli or a reminder of these stimuli (through senses of sight, smell, sound, taste, touch, body movement, balance).
- Increased startle response.
- Problems with sleep and appetite.
- High or low resting heart rate.
- Problems with relationships with others.
- Intrusive memories, e.g. flashbacks, nightmares (Perry, 2000; Phillips & Shonkoff, 2000; Van der Kolk, 1996).

It is important to note that although childhood is the most vulnerable period in terms of brain development and the impact of trauma, all of these potential impacts of trauma can impact on adults. It is also likely that most of the parents and even some carers will have experienced childhood trauma that is continuing to influence their life in adulthood.

The human brain develops in a *use-dependent* way. The more a person does something, the more her or his brain changes to make that function easier and quicker to do over time. Although this is highly adaptive when learning a new skill, for those who are frequently overwhelmed with adversity, their brain may adjust to a hyperaroused or dissociative state as the new baseline. In that circumstance, fight and flight reactions can be the predictable behavioural response, instead of the exception (Perry, Pollard, Blakley, Baker, & Vigilante, 1995). Use-dependent development also means that for children, young people and parents/carers who did not have the opportunity to use their brain in certain ways as a young child, such as through play, hugs, and communication, it will take longer and a more concerted effort to develop these and other abilities later in life (Jackson et al., 2013).

In some situations where fighting or running is not possible, the person may freeze, such as through dissociation. Breathing slows down and endorphins are released that help them to be very still or become numb and so feel less pain. They withdraw attention from the outside world and focus on the inner world. It may involve a detached feeling, as if they can make themselves ‘disappear’ and watch what is going on from a distance while

having the sense that what is occurring is happening to someone else (Van der Kolk, 1996). This can be adaptive but can also lead to negative consequences such as self-harming behaviours, blanking out in class and not being connected to others (Perry et al., 1995).

It is also important to remember that memories (and therefore physiological responses belonging to the trauma) can be activated by triggers that are associated with the traumatic experiences. Triggers can be internal to the person, such as thoughts, feelings, images, or sensations, or external, such as objects, places or people. In all therapeutic work, counsellors need to be mindful of triggers and ensure the child, young person or adult can stay within their 'Windows of Tolerance'; that is, the level of arousal that the person can tolerate without becoming hyperaroused or hypoaroused (Ogden et al 2009 in Fosha, Siegel, & Solomon, 2009).

Dissociation in children and young people is often not recognised since some of the external indicators such as 'day-dreaming' are common. However, pathological forms of dissociation can have significant effects on children/young people's development. It is important for counsellors to be alert to the possibility of dissociation in children and young people referred to CPCS. Symptoms of dissociation can include what looks like general forgetfulness, and is often noticed by parents, carers or teachers; memory problems such as amnesia for aspects of their experience; trance-like behaviour such as blanking or zoning out. It can also include development of self-states with different roles and behaviours, extreme changes in mood and behaviour, auditory and visual hallucinations, and/or feelings of depersonalisation and derealisation (Gomez, 2013).

There are different models that conceptualise dissociation, but its formation appears to be underpinned by two factors — the persistent absence of an emotionally available parent/carer and the presence of a frightened or frightening parent/carer (Gomez, 2013). These were identified in the discussion on attachment, and are consistent with Bowlby's description of detachment and the disorganised attachment style. Dissociation represents a child/young person's attempt at managing overwhelming stress without the protection and support of an attuned parent/carer and managing the internal conflict of wanting to flee the parent/carer and to be comforted. When the child or young person does not have opportunity for repair of the relationship, dissociation becomes a patterned response to the experience of attachment needs (Gomez, 2013).

Counsellors need to assess for dissociation in children, young people and adults. Screening tools are available that can be combined with clinical interviews to provide a useful assessment. These are available free of charge in the public domain:

- Children aged 4-12: Child Dissociative Checklist (CDC). Can be filled out by parents or carers familiar with the child (Putnam, 1997).
- Adolescents: Adolescent Dissociative Experiences Scale (A-DES) (Putnam, 1997).
- Adults: Dissociative Experiences Scale (DES) (Bernstein & Putnam, 1986).

As mentioned in Section 6.1 on assessment, these and other tools must be used in accordance with the relevant supports and supervision and not to label a person.

State dependent functioning

Another important principle of human functioning is that it is *state dependent* (Gaskill & Perry, 2014; Perry, 2001). In other words, everyone can be affected at any given time by their physical, emotional and relational state. This means that when a person is under threat, tired or unwell, they are unlikely to function as effectively and efficiently in their interactions, or deal with major changes or tasks.

Understanding trauma theory and state dependent functioning not only has implications for assessment for children and young people, but also for parent assessment.

> Parenting is not just about capacity, but also about day-to-day functioning. A parent may have more capacity than his or her presentation on a bad day would indicate. Rather than focusing on parenting capacity as a finite concept, we should include the concept of state dependence. A useful question to consider is what makes a particular parent more stressed or calmer. In particular, what may make them feel unsafe or safe. From what we know from neuroscience, if a parent is feeling under threat then they are likely to be:
>
> - Less able to take in new information;
> - Less able to try new ideas;
> - Less able to trust others, especially people they do not know;
> - More limited in their sense of time and capacity to delay gratification;
> - More limited in their capacity to think of anything other than survival;
> - More limited in their capacity to cope with transitions and change, including reunification;
> - More likely to dissociate or be hyperaroused or fluctuate between these;
> - Less able to integrate their internal and external worlds;
> - Less able to calm and regulate themselves; and
> - Less able to calm and regulate someone else, such as their child. (Jackson et al., 2014, pp. 45-46).

Trauma can pervade through the generations. Intergenerational trauma can incorporate community-wide series of traumatic events, such as Holocaust survivors, the impact of colonisation and Stolen Generation policies towards Aboriginal people (Raphael, Swan, & Martinek, 1998). Intergenerational trauma can also occur within a family over generations, such as when there is a generational pattern of trauma, abuse and deprivation (Karfgin, 2002).

> Their own histories of childhood trauma may have become an anchor that drags through their life into adulthood and parenthood. They may continue to live in chaotic and dangerous situations that make it near impossible to focus on anything other than survival (Jackson et al., 2013, p. 38).

CPCS counsellors are well positioned to assist parents/carers, children, and young people to deal with these transgenerational impacts of trauma; providing a safe therapeutic relationship for parents/carers which can assist them to improve their parenting capacity by ensuring their own trauma is not activated.

Secondary and vicarious trauma

The term 'secondary trauma'[13] refers to experiences that occur after an initial trauma, as a result of that event or the subsequent actions or inactions of others (Herman, 1997). It can include some unavoidable corollaries of the initial experience such as painful medical treatment, adversarial legal action or a child/young person being removed from their family. Although unavoidable, these situations may still be the focus of intervention to mitigate or reduce their negative impact. Other secondary traumas may not be inevitable but induced by people's lack of understanding, disbelief, denial, blame or even poor professional practice (Jackson et al., 2013).

Whether avoidable or not, secondary trauma can lead to a number of additional consequences such as increasing the risk of harm; complicating the person's efforts in recovery; and interfering with their capacity to access and benefit from social supports (Pynoos, Steinberg, & Goenjian, 1996).

Family responses and actions can also be a source of secondary trauma. Working with families to repair relationships and to understand the impact of trauma on their relationship is an important role for CPCS.

Family members themselves can experience trauma through witnessing the impact on their loved ones or learning about it. For example, parents or grandparents may be deeply traumatised at learning about their (grand)child's abuse. There are many reasons why family members need support in dealing with the impacts of their trauma:

- This is another form of secondary or vicarious trauma, which can have the same impact on them as direct exposure to the trauma.
- Their responses can be a source of trauma for other family members.
- Family members' own trauma response can inhibit their ability to support each other.

Counsellors and other practitioners can also experience vicarious trauma, which occurs as a result of being exposed to the trauma of their clients. This is discussed in detail in Section 10.4.5. That discussion underlines the importance of understanding the potential impact when a practitioner is feeling overwhelmed or under threat, and the commensurate need for greater interpersonal and organisational supports at this time.

[13] The term secondary trauma sometimes refers to vicarious trauma (VT) and that is discussed separately.

Appendix 7: CPCS practice approaches

Trauma-informed, violence specialist practice

Being trauma-informed

Trauma-informed care, trauma-sensitive practice or a trauma-informed approach is based on an understanding and acknowledgement of trauma theory. The key element of this approach is that the care model aims to provide a safe, supportive environment to clients and staff that reflects available research about the prevalence and effects of trauma exposure, and the best methods for supporting clients exposed to trauma (Wall, Higgins, & Hunter, 2016).

To be considered trauma-informed, an agency would have moved through the following transformative steps: being trauma aware (seek information out about trauma); becoming trauma sensitive (operationalise concepts of trauma within the organisation's work practice), be trauma responsive (respond differently, making changes in behaviour); and ultimately move to becoming trauma-informed (entire culture has shifted to reflect a trauma approach in all work practices and settings) (Wall et al., 2016).

The key principles derived from trauma-informed models of care that are directly relevant to CPCS, include:

1. Promoting a safe physical and emotional environment where the child and family's needs are met and safety measures are in place.
2. Understanding trauma and its multiple impacts, including recognising the adaptive intent behind many of the trauma associated behaviours.
3. Being culturally respectful and informed, particularly in the context of past and present experiences of trauma and healing.
4. Supporting client's control, choice and autonomy, and working towards genuine autonomy and a respect for human rights and freedoms.
5. Dealing directly with issues of power, such as recognising that the greater the power difference the greater the sense of threat.
6. Acknowledging the need for precautions to reduce the likelihood of being a further source of trauma.
7. Collaborating with services to provide an integrated and holistic response to support recovery.
8. Promoting safe and genuine relationships.
9. Acknowledging counsellors and other colleagues also need to be safe, supported in the face of vicarious trauma (VT), have a voice and be treated with respect.
10. Recognising the importance of hope, peer support, being strength-focused and future orientation.

Trauma-specific services

In addition to being trauma-informed, CPCS are a trauma-specific service. A trauma-specific service is one that is aware of the possibility of ongoing or re-traumatisation of clients and of the direct and indirect impacts on its staff and takes steps to reduce this wherever possible. A trauma-specific service recognises there are many potential pathways to recovery and to building resilience in clients.

Some features of a trauma-specific service include:

- Staff training in the impact of trauma.
- Use of standardised and evidence-based assessments of trauma history and symptoms.
- Use of trauma-focused therapeutic interventions.
- Supporting and developing emotional regulation with families.
- Actively seeking the participation of the child, family and community in planning and delivering interventions and in providing feedback about what has been achieved.
- Providing services that are strength-based and promote positive development by building on the strengths, knowledge and lived experience of the individual, family and community.
- Utilising written policies that explicitly include and support trauma-informed principles (Johnson, 2017).

Contextualising trauma

It is essential that practitioners working in a violence, abuse and neglect service using a trauma-informed approach acknowledge and draw on the following key concepts:

- human rights and social justice;
- privilege and power;
- gender inequality; and
- the politics of trauma.

It must be recognised that trauma is a response to violence and abuse. A trauma informed framework in the context of violence cannot minimise, rationalise, or pathologise violence and abuse. Trauma informed practice must move beyond the micro-level of the individual (which can continue to reinforce experiences of disempowerment and oppression, and continue to 'blame' the individual for their responses), to also incorporate the socio-political context in which families live (Quiros & Berger, 2015).

The socio-ecological model (as described in Section 1.2) is a useful tool to draw on when working in a trauma-informed service. An example of how this model can be applied to understanding child abuse and neglect is also provided in Appendix 3. Key concepts from Response-Based Practice also provide an understanding of the impacts of violence and

how to work with children, young people and their families who have experienced that violence. Response-Based Practice is about recognising individuals' inherent ability to respond to adverse situations in the form of resistance. Resistance can take many forms and can often be hidden. Examples may include actions from overtly standing up to a perpetrator through to small acts or thoughts of resistance that go unnoticed by others. Focusing on a victim's responses to adverse situations and working with those strengths is known as Response-Based Practice (Wade, 2007).

Child/young person-centred and family-focused practice

Adopting a child/young person-centred and family focused approach is not only important in terms of enhancing the realisation of positive outcomes, but will improve the likelihood of effectively engaging children and their families. Child/young person-centred and family-focused approaches are not mutually exclusive. While 'child/young person-centred' refers to placing the needs of the child/young person at the heart of any decision, being family-focused recognises that the issues and needs of parents will impact on the child (Family and Community Services, nd). It is critical that practitioners work with the whole of the family, considering each individual's specific needs in terms of safety and wellbeing in the context of their social environment.

Focus on families as a whole

Evidence-informed interventions all have a strong focus on families (Macvean, Sartore, Shlonsky, Albers, & Mildon, 2015). They also recognise that families are a system, not a collection of individuals. Therefore what happens to one family member, including interventions that target one person, inevitably impact on others. This not only includes the child/young person's immediate family, but their extended family and their caregiving family. As each individual member progresses through the life span, his or her individual development impacts upon, and is influenced by, the development of other family members. Each family therefore has its own life cycle. Each generation deals simultaneously with the challenges of their own development, together with the impacts of the other generations. Events within a generation have an impact on others and thereby shape and influence the development of those around them. A whole-of-family response means understanding the unique developmental challenges the family is facing, individually, and as a whole.

Workers need to be mindful that when they intervene with one member of a family, those interventions have consequences for relationships in the family as a whole, not just for the individual who is the focus of intervention. This can be used to target interventions most likely to promote benefit to vulnerable family members.

Drawing on family therapy, anti-oppressive practice, critical reflective practice, strengths-based practice, response-based practice, and the bio-ecological systems perspective, CPCS intervention usually involves promoting opportunities for healing and recovery, support and positive connection for the child/young person and family unit as a whole. This often means working with both parents/carers and the child/young person. Regardless of whether the child/young person lives with their biological family, the family is always held in mind and issues related to a carer's history are also considered in the context of trauma, attachment and family systems perspectives. Types of work with

families can include therapy to help a child develop capacity for self-regulation, to make sense of the trauma experience, and to process and integrate the traumatic memories. Other work could include providing psycho-education for the child/young person and their family/carers about the implications of trauma for the child/young person and others.

Working in partnership with families

Building partnerships with families and including their views is fundamentally important and reflects a trauma-informed response. Parents/carers need to be engaged in goal setting for their children and themselves and in contributing to safety. As well as ensuring basic values like transparency and respect, collaborative practice means including the family in decision-making (Dorothy Scott, 2012).

'Parents, play and home environments are critical to child health and wellbeing outcomes. Parenting is so influential that it can moderate the impact of social and economic disadvantage' (Fox et al., 2015, p. 2). Parents/carers who abuse or neglect their children often face significant challenges that impact on their parenting capacity. Vulnerabilities in families such as parental experiences of mental illness, substance misuse and domestic violence in the home can contribute to experiences of abuse and neglect for children and young people if the issues are not identified and addressed. A legacy of childhood abuse or trauma they had experienced may also increase the potential for a parent to maltreat their own children (Davies & Ward, 2012, p. 101).

Interventions that improve parent outcomes also improve outcomes for children and young people. Assessments need to identify which issues for parents negatively impact parenting capacity and target interventions to these. Working on improving parental skills and aspects of parenting that are not beneficial for the child/young person will have beneficial outcomes for the child/young person (Davies & Ward, 2012, p. 99).Approaches need to deal with the underlying trauma as well as to build skills, knowledge and resilience in families. We also need to learn from the many families that have broken this intergenerational cycle.

Workers need to develop skills and confidence to work with all members of a family, including children, young people and adults. Everyone cannot be a specialist in all areas of practice, but most practitioners can develop adequate skills and knowledge to engage, understand, and build a relationship with all family members. This is particularly important when working with a family where there is domestic and family violence.

The Safe and Together Institute approach to child welfare is predicated on model principles and critical components upon which practitioners from statutory and non-statutory backgrounds can work collaboratively and reach consensus to ensure the safety and wellbeing of children/young people living with domestic and family violence. These foundational elements aim to enhance the safety of the non-offending parent (usually the mother) by: partnering with her; supporting her protective efforts in keeping the child/young person 'safe and together' with her; and intervening with the offending parent (usually the father) to reduce the risk of harm to the child/young person and to hold him to account for his use of violence and coercive control (Humphreys et al., 2018).

Strengths-based practice

Critical to effective work with families, children and young people is a focus on strengths not just vulnerabilities; which requires a thoughtful analysis of both deficits and strengths. Supporting family members to 'discover resources' in themselves 'however small' shifts the focus from problem finding to 'solution building' and allows the family to participate in finding and creating 'building blocks for change' (Edwards & Turnell, 1999, p. viii).

A strengths-based approach does not mean ignoring risks or minimising harm. Rather it contributes to a partnership that is built on transparency and engages vulnerable families in a process of finding hope. Managing the balance between working with strengths while acknowledging vulnerability requires a constant process of assessing, establishing, monitoring and sustaining safety.

Collaborative practice and integrated service delivery

Research has shown the crucial role of ongoing liaison and work towards effective collaboration between agencies working with children, young people, parents/carers and families where the child/young person is at risk. No single service or service system has the capacity or expertise to respond to the needs of every client. Many clients engage with a range of services during their lifetime and for many people navigating the service system can itself be traumatic (Australia. Royal Commission into Institutional Responses to Child Sexual Abuse, 2017a). Work that enhances development, prevents abuse, and responds to the causes and impacts of violence, abuse and neglect, are likely to be multi-systemic in nature.

While the value of collaboration between services is evident, the different histories, knowledge bases, and organisational cultures of each sector (such as child protection, domestic and family violence, mental health and drug and alcohol) present formidable challenges to the development of effective working relationships and the sharing of respective expertise (Laing, Irwin, & Toivonen, 2012). Scott (2005) identified five sources of conflict between services that can interfere with collaboration and partnership building that were present at every level from individual to organisational relationships. These included inter-organisational, intra-organisational, inter-professional, inter-personal, and intra-psychic, and problems in one level could lead to conflict at another level.

While being difficult, a collaborative, interagency approach is critical in responding to families. Evidence of the negative consequences of fragmentation, disconnection and 'siloed' service delivery and the benefits of collaboration means that collaborative practice and integration are widely regarded as best practice in responding to children, young people and families who have experienced violence, abuse and neglect, particularly when parents have multiple risk factors of mental illness, substance use and dependence and the presence of domestic and family violence.

Collaborative work spans across all system levels and can include: interagency partnerships; government policy directives; and challenging of broader social values held in the community. Although CPCS are not responsible for undertaking every intervention, it is useful to understand that additional services may be needed beyond the capacity of

the CPCS. This is an important reminder that the goals of the work are tailored to the child/young person and family and CPCS will harness resources in collaboration with others from within and without to ensure the child/young person, family and carers are given the best chance to reach these goals.

Formal and informal integration, coordination and collaboration can take many forms which are best represented through the concept of a continuum of integrated service delivery as illustrated below in Figure 6 (Wilcox 2010 reproduced from (Breckenridge, Rees, Valentine, & Murray, 2015, p. 10).

Figure 6: Continuum of integrated service delivery

Service autonomy	Collaborative practice	Streamlined referrals	Cooperation	Coordination	Integration
With networking	Formalised networking arrangements and organisational policy development	Incident-based processes, such as police faxbacks	Regular communication around clients and some common goals	Agreed plans and protocols or a separately appointed coordinator	Single system with sub-units and cross-unit accountability

Source: Wilcox (2010, p. 1020).

Regardless of the level of integration along this continuum, key features of successful partnerships between agencies identified from the evidence are:

- 'communication — both formal and informal;
- trust — at each level including between sectors and agencies;
- shared goals — transparency of agreed intervention goals;
- shared language;
- equity between agencies — the role of each agency are equally valued; and
- leadership — some literature suggests a lead agency is helpful, but all acknowledge that management of client need is important' (Breckenridge et al., 2015, p. 12).

The *Child Wellbeing and Child Protection — NSW Interagency Guidelines* offer collaborative strategies to promote access to services and better integration of service delivery. This is important to facilitate referrals to Child Protection Counselling Services (CPCS), and to ensure that CPCS is aware of and able to access additional services to support its interventions with children/young people and families/carers. The Interagency Guidelines emphasise the importance of:

- **Building and contributing to better local networks** which foster an understanding of the local agencies.
- **Agreeing on better ways to work together to support shared clients** that may involve joint case planning, case conferencing, or cross-agency referrals. These processes help services to consider information about a child/young person or family from their respective professional disciplines, and to consider the best mix of supports.

- **Establishing partnerships** to develop integrated responses and address service delivery gaps.
- **Establishing formal protocols** to ensure that the roles and responsibilities of all services in supporting children, young people and families are clear, such as through Memoranda of Understandings or protocols.
- **Creating opportunities for shared training** which provides a strong foundation for interagency practice. This would improve understanding of services' roles and responsibilities, as well as promoting a shared language, knowledge and awareness between agencies.
- **Recognising the function of strengthening relationships** between services, such as within position descriptions and other ways of articulating shared expectations.

Consistent with the Interagency Guidelines, CPCS will maintain close interagency relationships and collaborate to provide coordinated, effective services and to promote quality service responses and continuity of care to children/young people and families/carers.

Appendix 8: Program theory underpinning CPCS practice

This appendix describes the emerging program theory underpinning CPCS practice. It has been informed from consultations with CPCS staff and other key informants, as well as by the literature.

Theory of change and theory of action

In order to effect meaningful change in the lives of children, young people and their families, there must be an understanding of what needs to change and how. This does not just draw on theories about the nature of the problems and evidence-informed interventions, but more explicitly on considering the mechanisms for change. Program theory is a means of grappling with these questions.

CPCS program theory has two components: theory of change and theory of action. Theory of change describes the mechanisms by which change may occur. Theory of action describes how the program is constructed to activate the theory of change (Funnell & Rogers, 2011). The theory of action has informed both the key elements of the CPCS program and the CPCS pathway.

CPCS has a dual focus which has implications for its theory of change. First is the focus on children and young people's recovery from trauma of violence, abuse and neglect. Second is the focus on the parent/s and/or carer/s and their ability to protect and care for the child/young person to ensure the child/young person's future safety.

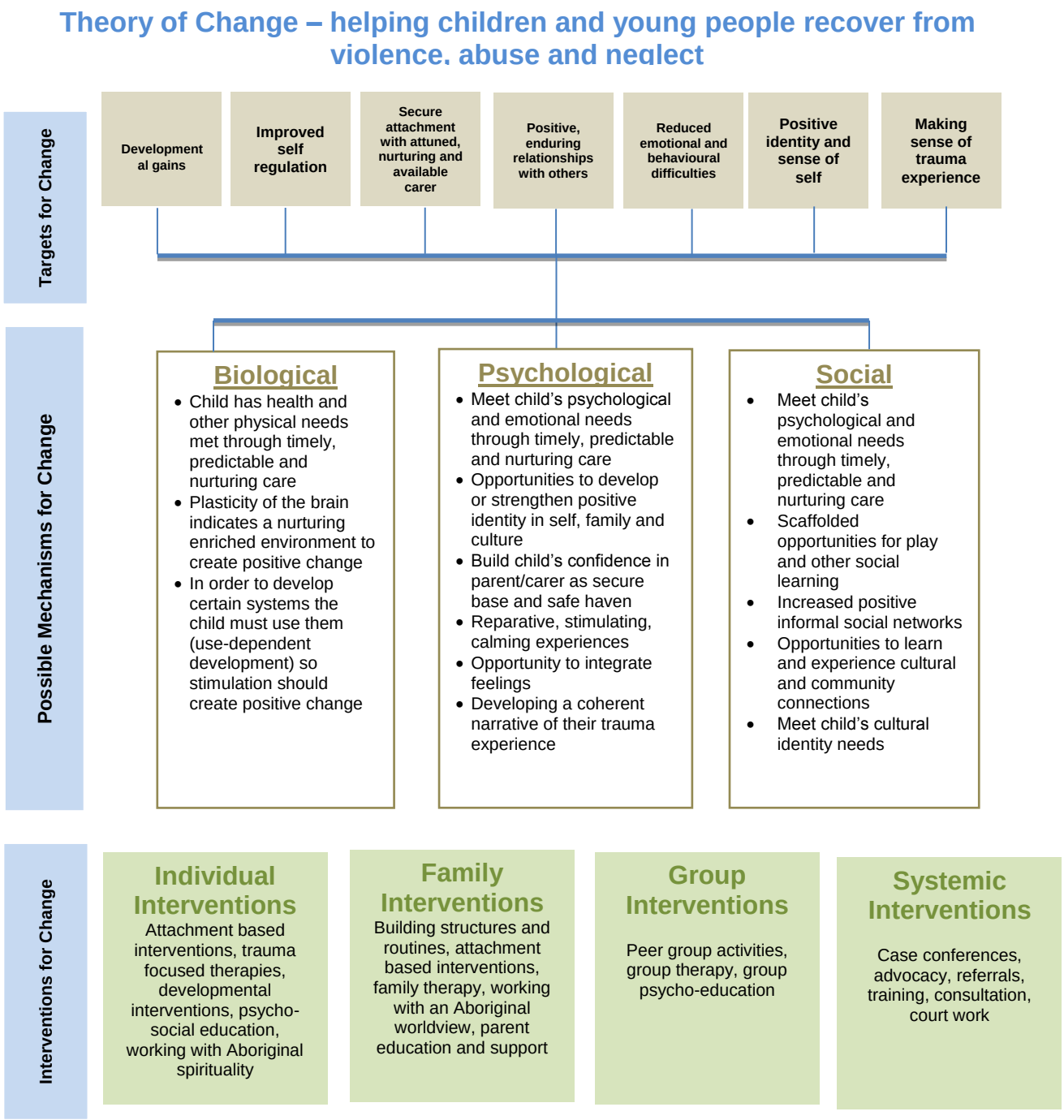
Figure 7 below portrays an emerging theory of change to explain children/young people's recovery from harms. It includes the common targets for change (outcomes) through the work of CPCS. These outcomes are primarily about redressing many of the consequences of trauma and disrupted attachment. To understand mechanisms for

change one must also understand the mechanisms by which violence, abuse and neglect cause harm. More discussion about mechanisms for harm resulting from trauma using a bio-psycho-social perspective, is found in Appendix 7. Although this figure separates the biological, psychological and social factors, these are interwoven. Figure 7 below lists some of the interventions used by CPCS to achieve the associated targets for change.

When viewing both Figure 7 and Figure 8 there are some important considerations around 'tasks for change' which include:

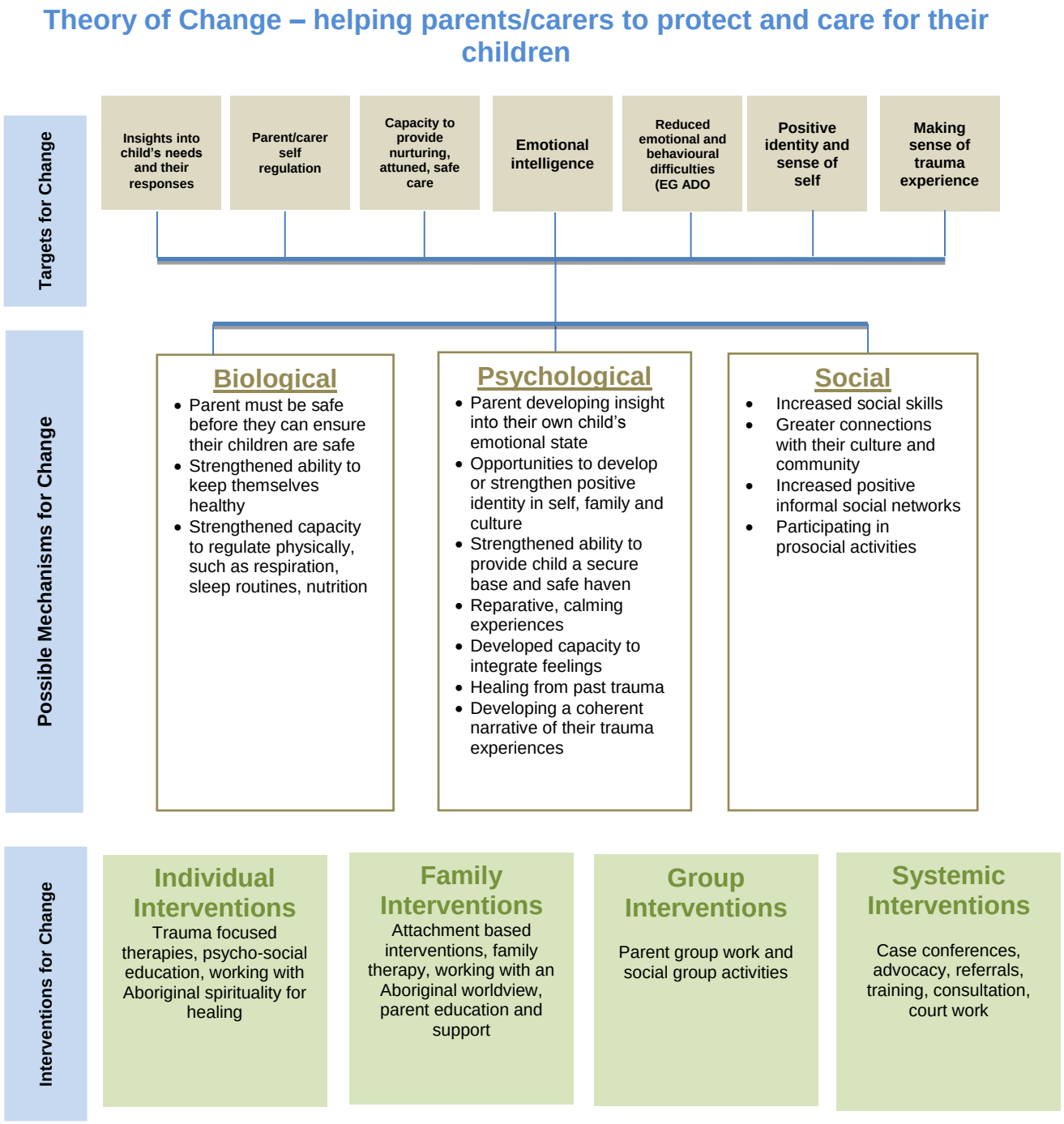
- The tasks listed in both tables are not discrete, nor exhaustive. They are inter-related and may be utilised at different points in time with clients of CPCS.
- The tasks may be performed in different contexts. For example:
    - to achieve safety where there is a risk (and to prevent removal of a child)
    - to allow for restoration, and
    - to work with carers if restoration is not possible and to ensure the child/young person maintains connection with their family.
- These tasks may be 'set aside' and/or supported by casework, advocacy and systems interventions.

Figure 7: Theory of change – Helping children and young people recover from violence, abuse and neglect



The second theory of change diagram shown in Figure 8 is focused on desired changes for the parents and other family members in order to protect the child from further trauma and helping the child in the process of recovery.

Figure 8: Theory of change – Helping parents/carers to protect and care for their children



Appendix 9: Critical reflection

The role of CPCS counsellors requires them to simultaneously make in-the-moment judgements as well as formulate evidence-informed interventions that are person-centred for each child, young person, and family member. At the same time as they are forming relationships with clients, responding empathically to distress, or identifying goals to work on, they may also be observing for signs of risk or assessing development. These tasks clearly require a practitioner to be emotionally attuned and responsive, as well as to think critically. Evidence from the neurosciences is that humans are well equipped to do this, but to make best use of these capacities, a process of reflection is required (Munro, 2008).

This process of reflection allows practitioners to optimise their capacity for critical reasoning and limit the likelihood of errors of judgement. It helps with the complex task of making in-the-moment decisions as well as more structured thinking and planning, and is based on an understanding of how the human brain processes information to form judgements. In forming judgements humans rely on two modes of reasoning: intuitive and analytical. Both have something to offer in the complex process of counselling; and each has its strengths and its limitations (Munro, 2008).

- Intuitive reasoning draws on information stored in the more primitive parts of the brain and is a largely unconscious process. It draws on experience — the patterns, emotions, meanings and images rooted in past experience. Intuitive reasoning is quick and effortless, but because it is based on experience, it is prone to bias.
- Analytic reasoning on the other hand, takes place in the neocortex; the sophisticated part of the brain where more complex cognitive processing occurs. It is a more conscious and deliberate process that draws on logic. Because analytic reasoning draws on empirical information and more formal forms of knowledge it is more reliable, but it requires effort and time.

Eileen Munro analysed child death reviews in the UK and identified the difficulties that occur when intuitive and analytic forms of reasoning are not well integrated. She noted common errors of reasoning that occur in making critical decisions. These included: relying on a narrow range of evidence; overlooking important information that may be known but not necessarily analysed; favouring information that is emotionally arousing and therefore memorable; and failing to revise judgments in the face of new information. (Munro, 2008).

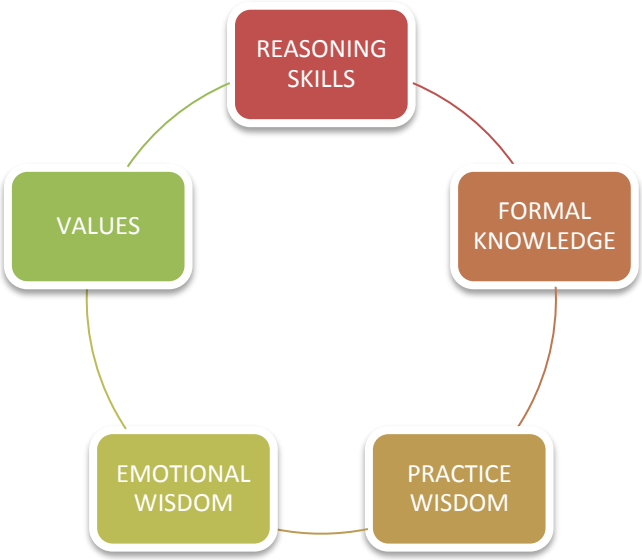
Recognising these common mistakes can lead organisations and systems to systematise processes so that there is less room for “errors of judgement”. This places more emphasis on formal theory and knowledge, and tends to rely on checklists, assessment tools and procedures. However, on its own, this can encourage ‘surface level thinking’ and an emphasis on compliance with policy and practice guidelines (Gibbs, 2008). At its worst it can lead to what one author called ‘conveyor-belt practice’ (Ferguson, 2004). This is characterised by focusing on getting cases through the system, meeting targets, and speedy casework resolution (Chapman & Field, 2007). It does not make best use of the human brain's capacity for complex reasoning.

To avoid this binary between the two modes of thinking, a process of critical reflection is required that utilises multiple sources of information and systematically checks intuitive forms of reasoning against objective evidence— that is, a process of reflective practice (Munro, 2008). Reflective practice is a term that is frequently used and there are many models that can be usefully applied. Three important characteristics of reflective practice need to be present in any model:

1. It involves a process of critical reflection that occurs before, during and after practice — *planning* for practice; reflection *on* practice; reflection *in* practice;
2. It utilises intuitive as well as analytic forms of knowledge; understanding is derived from integration; and
3. It derives learning and new knowledge from experience (Thompson & Pascal, 2012).

Munro (2002) identified five sources of knowledge and skill needed to make effective judgements when working with children, young people and families in the child welfare field. These involve both intuitive and analytic forms of reasoning and draw on formal knowledge, practice wisdom, emotional wisdom, values and reasoning skills.

Figure 9: Five sources of knowledge and skill (Munro, 2002)



1. **Formal knowledge** assists analytic reasoning. It includes laws, policies, procedures, and tools based on empirical research. For CPCS counsellor's essential sources would include, but are not limited to:
    a. violence, abuse and neglect (VAN) policies and procedures and the associated VAN Service Standards;
    b. other relevant legislation and NSW Health policies and procedures;
    c. local Health District systems and processes;

d. the Evidence Check literature review (Macvean et al., 2015) in relation to interventions for families with complex needs, where children and young people have experienced violence, abuse and neglect; and

e. other literature about the nature of the client group, interventions, etc.

2. Practice wisdom is an intuitive form of knowledge that is built on experience in the field and in the social world more generally. It draws on implicitly understood patterns of behavior, experience of similar situations, the 'mind reading' skills derived from the social brain (Lieberman, 2007) and 'gut feelings'. Practice wisdom is needed in the moment-to-moment interactions with children and families. It can also inform *how* to do something that formal knowledge would indicate needs to be done, by allowing a nuanced and attuned response from the practitioner.

3. Emotional wisdom draws on the ability to recognise, process and utilise emotional information. For example, a CPCS counsellor undertaking a home visit may feel afraid. The source of the fear could relate to an actual or perceived threat to safety, picking up on fear felt by one of the family but not directly expressed, or even an activation of the practitioner's own feelings associated with previous trauma. Being able to identify the feeling, process it, manage one's own response and utilise it to inform the next step, all require a high level of emotional capacity. The ability to use emotional information requires the counsellor to be well supported, and for supervision and reflective processes to value the role of emotions in decision-making.

4. **Values** may be explicit, such as those defined in ethical or legislative frameworks, or they may be implicit or even unconscious. Ensuring that values that may be influencing decisions are made explicit means they can be examined and used appropriately. Values that are not explicit or remain unexamined can lead to discriminatory or unethical behavior.
5. **Reasoning skills** act as the facilitator in the process of integrating analytical and intuitive sources of information. They enable a practitioner to step back and analyse critically the information available, and to balance the different modes of reasoning. This ensures critical decisions are reflective and draw on all relevant information available at any given time. Because humans can never be perfect, and because risk is dynamic and dependent on a range of interacting factors, 'mistakes' can occur. A reflective organisation, supervisor and practitioner will recognise that mistakes occur, will learn from them, and will ensure that these learnings inform future practice

Appendix 10: Further information for client services

This appendix provides more detailed information on engagement strategies, assessment and interventions with families which add to section 6 of this document.

Engagement strategies

When thinking about developing working relationships with families, strategies to promote effective engagement with the child/young person and family/carers can include:

- An introduction meeting with the family and the FACS worker, NGO case worker, or other referrer. This is an opportunity to establish shared understandings of the safety concerns and gain a concrete idea of what the referrer needs to see to believe that the violence, abuse and neglect concerns are resolving or resolved.
- Planning and preparation for visits, especially first contact. This includes gathering and reading relevant information about the child/young person and family/carers.
- Developing a holistic picture of the child/young person and family/carers and their context, while also being open to hearing first hand from the child/young person and family/carer about their own situation.
- Learning from the child/young person and family/carers as well as from others who have worked with them about what has or has not worked.
- Tailoring strategies for engagement based on this information and being responsive to their wishes whenever possible, such as location and timing of contact; whether they wish someone else to be present, and whether they need transport, interpreters, child care or other practical assistance.
- Prepare for culturally appropriate engagement with children/young people and families from Aboriginal or culturally and linguistically diverse backgrounds. (Strategies for engaging Aboriginal children/young people and families are provided in more detail in Section 8.)
- Be informed and sensitive to children or parents with additional needs such as disability which may affect accessibility and engagement.

When children/young people are in out-of-home care (foster care, kinship care or residential care), their carers are an essential part of the therapeutic process for the child/young person, and often for the family. The carers' role is pivotal in helping the child/young person make sense of their day to day experiences. Referral goals may involve assisting carers to respond to the child/young person's complex needs as shown through certain behaviours as a result of trauma. Research has also shown that carers directly involved with parents can support the process of reunification and so engage them in this process which can make a substantial contribution to the outcomes (Jackson et al., 2014).

Although initial engagement with the child/young person, family and carers sets the scene for ongoing working relationships, engagement is an ongoing process. Ongoing engagement with children, young people, families and carers requires paying attention to

avoid potential pitfalls and acting on opportunities to build on positive experiences. Additional strategies include:

- Being clear about the counsellor's role and the roles of others.
- Being clear about the child/young person and parent's rights and how CPCS works to protect those rights.
- Being clear what is negotiable and non-negotiable, and maximising choice as much as possible.
- Being respectful and reliable, such as by keeping appointments and returning phone calls in a timely manner.
- Not making promises that cannot be kept.
- Maintaining good records and ensuring the records accurately reflect what was said and agreed to at meetings, especially where key decisions or agreements have been made.
- Promoting and facilitating conversations with the child/young person and their family, including extended family and community when appropriate.
- Acknowledging that the counsellor, family and carers usually have a shared interest in wanting what is best for the child/young person and spending time finding out what this looks like.
- Ensuring there is a coordinated transition if a counsellor is on leave or there is a need for a new counsellor to be allocated.

Approaches to building trust with the child/young person need to be age and developmentally specific. It begins with the CPCS counsellor providing age-appropriate information about their role and the nature of their work with the child/young person and their family/carers. In this way children/young people are as prepared as possible for what to expect and able to ask questions and express feelings or concerns. Assessment and clinical judgement will inform how the sessions are conducted. This includes the venue, time of day, who is included in the sessions, the child/young person's personal preferences and which clinical "tools" may be used. Age-appropriate play, ongoing psycho-education about what is happening in therapy, enabling the child/young person to have personal space and creating opportunities for parallel interactions are part of the counsellors tool kit in engagement. This is particularly important for children or their parents/carers who may be overwhelmed by intensity in relationships (Berry Street, 2015).

Assessment

Assessment for the purpose of this Child Protection Counselling Service (CPCS) Policy and Procedures refers to an evaluation of the safety and wellbeing of children, young people, parents and carers as well as of their social, psychological, emotional, mental, physical, and any other health needs.

Assessment, no matter how brief, allows for a relationship to start, or continue, to be built and expectations to form. Clinical assessments must not only be a static, one-off

process. Rather, good practice in clinical assessment requires an ongoing dynamic process of assessment, analysis, review and response by the counsellor/s in partnership with the child/young person, their family/carers and other professionals. Such assessments may be formal or informal and will take place during each individual intervention as well as across multiple interventions or interactions with the child/young person and family/carers.

In accordance with this dynamic and collaborative process of assessment, assessment in CPCS work is designed to be transformative, rather than simply a process of collecting information about a client. The manner in which the questions are asked of the client also has a therapeutic purpose and intention. Although the focus of this section is on formal comprehensive psychosocial assessments (including initial assessment and planning and review), ongoing informal clinical assessments are also an important part of clinical practice.

Clinical outcome measures

There is a suite of recommended core outcome measures, as applicable for each child/young person and their family. These core measures are as follows:

- **Strengths and Difficulties Questionnaire (SDQ)** (Goodman, 1999) **3-16 year olds** – brief behavioural screening questionnaire. Versions can be completed by child/young person (8 years or older), parent and/or carer, and teacher.
- **Depression Anxiety Stress Scale (DASS)** for parents and carers to assess parent/carer mood (depression anxiety and stress). It can also be completed by adolescents (Lovibond & Lovibond, 1995).
- **Health of the Nation Outcome Scales for Children and Adolescents (HoNOS/CA)** (Gowers et al., 2000). The HoNOS is the adult version. These scales are completed by the counsellor.

If another service currently involved with the child/young person is applying the same measure (e.g. a Family Preservation service applying the NCFAS), then CPCS and that service may decide to collaborate and share the results of the measures, with consent from the child/young person and/or family/carers where possible. Different CPCS teams may decide to use other measures in addition to, but not instead of, these core measures.

All outcome measures must be used and interpreted in accordance with the measures specifications. Each CPCS counsellor will become familiar with these specifications through the relevant manual or online or other types of training. Outcome measures should be for the purpose of informing intervention planning with the child/young person and family/carers and not solely to label or diagnose them. If a measure is used with a child/young person or family member who is Aboriginal or from a culturally and linguistically diverse background, additional caution should be applied in its application and interpretation.

Care should be taken not to over assess. Many of the children/young people and families referred to CPCS have undergone multiple assessments and these should be accessed

as much as is practicable. Careful consideration should be given to the administration of additional assessments above and beyond the core measures to reduce the risk of over-assessment which impedes engagement and timely intervention.

Specialist assessments

Specialist assessments may be recommended to ensure the assessment process is comprehensive; however, care should also be taken not to over assess as noted above. These specialist assessments may include:

- Paediatric health assessment.
- Psychiatric assessment.
- Cognitive assessment (e.g. WISC-V).
- Occupational Therapy (e.g. sensory profile).
- Cultural assessment.
- Speech and Language assessment.
- Vision tests or assessments.
- Hearing tests or assessments.
- Neuropsychological assessments and analysis (these may analyse tests such as cognitive assessments already completed, as well as undertaking further assessments, such as on executive functioning and impulsivity).
- Alcohol and/or other drug assessment.

It should be noted that, although a child/young person may present with symptoms consistent with a mental health diagnosis, it is not the CPCS's role to provide a diagnosis.

Considering parenting capacity

When the goal of referral to CPCS includes family preservation or restoration, parenting capacity forms a key element of the primary focus of assessment. Parenting capacity is one of three core elements which practitioners assess when concerns about a child's welfare are raised. The other two elements are the child's developmental needs, and wider family and environmental factors. These three elements are inter-related and cannot be considered in isolation. Parenting capacity refers not only to the willingness of the parent/carer to meet the needs of the child, but also their ability to do so. As CPCS are usually not in a position to assess all aspects of parenting capacity in isolation, this often occurs in collaboration with other services such as FACS and/or the NGO family preservation/restoration or other referral service as appropriate.

A central question associated with assessing parenting capacity is, 'can these parents provide a safe and stable environment that will support the child in both physical and psychological development?' (Steinhauer, 1991 cited by Choate, 2009, p. 53). In considering this question, it is important to take into account a parent's level of:

- Knowledge – Does the parent/carer have the information and understanding to recognise the needs of the child/young person?

- Skills – Does the parent/carer have the skills to regulate their own behaviour and to care for the child/young person?
- Motivation – Can the parent/carer protect the child/young person; do they prioritise the child/young person's needs?
- Material and personal resources – Does the parent/carer have access to the resources that will support and sustain them in their caregiving role, for example connections with family and community and access to support services?
- Opportunity – Does the parent have time and space to consider and respond to the needs of their child/young person? (Reder, Duncan, & Lucey, 2003).

Barriers to parents/carers being able to meet the child/young person's needs should be identified as part of the assessment. Assessment of motivation or ability to change is not likely to be accurate until some trust is established between the family and the service; however, all the above factors may be potential targets for change.

Important factors that may impinge on parenting capacity include whether a parent/carer has a mental health or substance use and dependence issue (where CPCS should assess the overall impact, in particular critical times of obtaining, using, times of withdrawal, and where the children are during these times), has experienced childhood abuse or neglect, is subjected to violence and/or is violent. These factors must be taken into account while also considering that parenting capacity is influenced by interactions between the child/young person's needs, development and characteristics, as well as the parent's abilities and limitations. Parenting capacity should be considered in the context of the parent-child relationship (Azar, Lauretti, & Loding, 1998; Choate, 2009; Donald & Jureidini, 2004; Pezzot-Pearce & Pearce, 2004; Reder et al., 2003) and is often best informed by observing children/young people and parents in a natural setting. This highlights the value of using outreach as part of the assessment process whenever possible.

Other key considerations when assessing parenting capacity may include:

- Psychometric or other structured tools can be useful but should not be overly relied on, as they each have limitations and can be overly utilised (Choate, 2009; Donald & Jureidini, 2004; Ostler, 2008; Reder et al., 2003; White, 2005).
- Ensuring the assessment is culturally aligned to the family's culture is crucial (Choate, 2009; White, 2005).
- It is important to interview parents separately if there are concerns regarding domestic and family violence or past history of trauma that is impacting their parenting capacity. This does not completely negate the risks but is an important step (Choate, 2009; Sturge, 2003).
- The children/young people should be interviewed and included in the assessment (Choate, 2009). This is not about asking the child/young person to comment on their parents, but rather listening to their perspective about their needs and how these are being met or not met, as well as their hopes and fears

- Where possible, there is a need to involve both parents in assessment, whether or not they are living with the child (Reder et al., 2003).

  Parenting is not just about capacity, but also about day-to-day functioning. A parent may have more capacity than his or her presentation on a bad day would indicate. Rather than focusing on parenting capacity as a finite concept, we should include the concept of state dependence. A useful question to consider is what makes a particular parent more stressed or calmer. In particular, what may make them feel unsafe or safe. From what we know from neuroscience, if a parent is feeling under threat then they are likely to be:

  - Less able to take in new information;
  - Less able to try new ideas;
  - Less able to trust others, especially people they do not know;
  - More limited in their sense of time and capacity to delay gratification;
  - More limited in their capacity to think of anything other than survival;
  - More limited in their capacity to cope with transitions and change, including reunification;
  - More likely to dissociate or be hyperaroused or fluctuate between these;
  - Less able to integrate their internal and external worlds;
  - Less able to calm and regulate themselves; and
  - Less able to calm and regulate someone else, such as their child. (Jackson et al., 2014, pp. 45-46)

Therapeutic interventions

Evidence-informed practice

Specialist health services and programs are expected to apply therapeutic interventions that are demonstrably effective. However, the evidence available for such interventions with children, young people and families affected by violence, abuse and neglect is mostly emerging or promising. Evidence is also almost completely absent in relation to some areas, such as helping children and young people recover from neglect (Jackson, 2014).

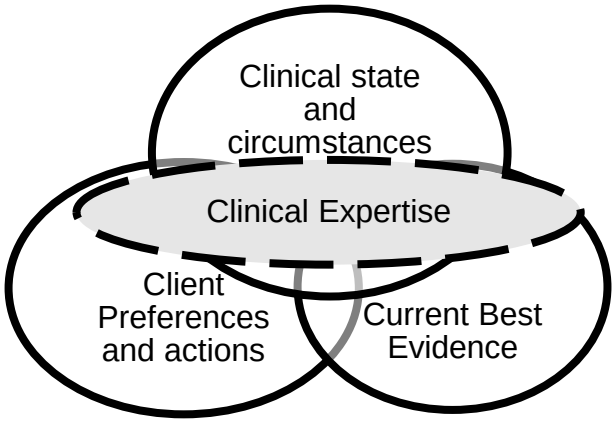
Evidence-informed treatments refer to an intervention subjected to empirical study, usually including randomised control trials (RCT), where there are findings that the intervention is effective with a particular client group. It is, however, rare that RCTs involve participants with multiple risk factors, changing placements and complex problems, as too many variables complicate interpretation of the results (Brandt et al., 2012; Chorpita, 2003). As a consequence, children and young people involved in the care and protection system are often excluded from RCTs (Chorpita, 2003).

Adapted from the definition by the Institute of Medicine, evidence-informed practice (as distinct from evidence-based treatment) is the integration of the best available research with clinical expertise in the context of client characteristics, culture, and preferences (Institute of Medicine (US). Committee on Quality of Health Care in America, 2001; adapted from Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000).

Evidence-informed practice (or evidence-based practice as these are often interchangeable terms) is a more inclusive concept than evidence-based treatment. Evidence-informed practice involves learning from research, including RCTs, as well as from other types of research and other sources (Brandt et al., 2012). It is a client and clinician directed process, rather than solely an application of research to a presenting problem. Evidence-informed practice relies on the clinician's ability to understand the child/young person and family's situation and safety, as well as the available interventions, and integrate all the elements. Evidence-informed practice enables practice to be more person-centred so that interventions can be tailored to the individual, including their needs, strengths and wishes (Brandt et al., 2012).

Figure 10 below portrays a conceptualisation of evidence-informed practice (Haynes, Devereaux & Guyatt 2002 cited in E. J. Mullen, Shlonsky, Bledsoe, & Bellamy, 2005). It is clinical expertise and judgement that integrates these different types of information to decide what interventions to use when and with whom. This is consistent with the Institute of Medicine's definition of evidence-informed practice.

Figure 10: Elements of evidence-informed practice (Haynes, Devereaux & Guyatt, 2002, cited in Mullen et al, 2005).



An evidence-informed approach requires clinicians to analyse the available evidence and ensure it stands up to its claims. An essential aspect of examining the evidence is to consider contra-indications of particular approaches for a given situation, or when evidence suggests a particular intervention may be harmful. An example of this is some misnamed 'attachment therapies' that recommend enforced holding and other coercive strategies (Chaffin et al., 2006).

Another aspect of evidence-informed practice is that interventions should be applied with fidelity, acknowledging that some interventions are more prescriptive than others. If counsellors aim to use a particular intervention they should be informed of all of its elements, whether or not training is required or recommended and available, whether there is access to supervision and consultation in the approach, and any other issues that may impact on decisions about whether the intervention is to be incorporated into their scope of practice. As most interventions with a claim to an evidence-base have been developed in other contexts and other countries, there should be careful consideration and processes for adaptation before utilising these (Kilbourne et al., 2013).

Practice principles which guide work with families where there are concerns about safety are:

- Understand the position of each family member.
- Find exceptions to the violence, abuse or neglect.
- Discover family strengths and resources.
- Focus on goals.
- Scale safety and progress.
- Assess parental willingness, confidence and capacity (Edwards & Turnell, 1999).
- Monitor the level and changing nature of risk and safety.

It is important to remember that, “parents with the most complex and entrenched problems appear not to respond to routine services” (Davies & Ward, 2012). As portrayed in Table 3 below, there are a range of interventions that have been identified as promising or where there is some evidence for effectiveness. Please note, however, that CPCS’s are not to use hypnosis (including Eye Movement Desensitisation and Reprocessing (EMDR) or any other technique that could be considered hypnosis) in the course of their therapeutic interventions with people who may become involved in the legal process. This position is based on the Office of the Director of Public Prosecution’s (ODPP) Prosecution Guideline 27 that the Prosecution will not tender evidence where its subject matter was recalled for the first time under hypnosis/EMDR and the potential for CPCS clients to be involved in the legal process in the future.

Evidence informed or promising Interventions (from Davies & Ward, 2012).
• Parenting interventions: o Parent-focused interventions work to improve parental skills and aspects of the

parents' wellbeing; they also address approaches to parenting that contribute to the abuse or neglect.
    - Underlying issues of family violence and substance use and dependence need attention first.
    - Improving affect regulation of parents with substance use and dependence issues has been helpful.
    - Target multiple domains of functioning, not one issue.
    - Target consequences of parents own childhood abuse – e.g. unrealistic expectations and distorted beliefs.
- Parent-child focused interventions:
    - Intervene on aspects of parental functioning and mental health.
    - Parent-child relationship, targeting both parent and child
    - Attachment based work, CBT, psychoanalytic.
    - Family therapy.
    - Target maternal and child representations.
    - Target parent-child conflict.
- Family-focused interventions:
    - Focus on mental health of each family member and interactions between them.
    - Can include whole families or subsystems.
    - Takes into account needs of whole family, multi-problem focus.
    - Intervention in communication patterns in the family.
    - Multi-systemic therapy.
- Child-focused interventions:
    - Help children cope with impacts of maltreatment.
    - Address immediate or long-term needs.
    - Infancy to adolescence.
    - Therapeutic preschool.
    - Peer social skills training.

Evidence-based principles for supporting children/young people's recovery while in out-of-home care include the need to:

- Provide safe environments and rich experiences that stimulate and enrich brain growth.
- Support children/young people and caregivers to understand the link between traumatic events and cognitive difficulties.
- Develop and support positive relationships and connections in children/young people's lives.
- Maintain targeted interventions throughout childhood and adolescence.
- Offer all children/young people in care targeted and trauma-specific interventions.
- Ensure that specific cognitive difficulties are addressed directly (McLean, 2016a).

Levering mechanisms for change — case example

Appendix 6 describes a bio-psycho-social lens for understanding possible mechanisms for change in the child (Figure 7) and for the parent/s (Figure 8). These inform possible interventions that could be the lever for each mechanism.

Following is an example of a four-year-old girl who has been banging her head on the walls and lashing out at other children in the child care centre. The assessment highlighted that one of her core difficulties is poor self-regulation.

Example of a target for change:

The child to develop capacity for self-regulation when distressed or angry so she does not harm herself or others.

Mechanisms to achieve this target include:

- Child to experience predictable, nurturing and responsive care.
- Adults to identify the triggers for the behaviour (external and internal) and plan for ways of managing triggers.
- Identifying if the behaviour relates to previous experiences of trauma, e.g. sleep time may be associated with occurrence of violence and/or it may be that the child never developed a sleep routine when growing up.
- Parent/carer to co-regulate the child when she is distressed or angry (which includes regulating themselves).
- Child to develop a regular sleep routine.
- Child to experience rhythmic, regulating and calming sensory activities at child care and at home.
- Child to learn other strategies to be soothed including self-soothing and letting others comfort her.
- Child to experience positive social interactions with peers at the child care centre or school.

Interventions to affect these mechanisms include but not limited to:

- Psycho-education with the child care centre to enable them to incorporate calming, rhythmic and regulating activities into the daily routine.
- Dyadic attachment-based work with parent/carer and child to strengthen attachment relationships so the parent/carer can co-regulate the child, and to practice rhythmic, regulating and calming activities.
- Engaging the parent and child in a therapeutic play group and/or play therapy to build on attachment and developmental goals.
- Individual work with the parent/carer to help them develop insight into the child's difficulties and how to respond to her when distressed.
- Individual work with the child to help her express her state of mind and feelings through play so she can use the therapeutic relationship to expand her self-regulation capacity.
- Referral to a paediatrician for a paediatric assessment and discussion as to whether a neuropsychological assessment may also be warranted.

It is not suggested that all this list of possible interventions are required, or that they should occur at the same time. Indeed, the sequence of interventions is important. Supporting the parent/carer to provide the child with nurturing, responsive and safe care is pivotal, if not already occurring, before other interventions can be effective. Similarly,

supporting the child's physical and relational environment to be regulated is an important early step before changes can be expected in other areas.

The choice of interventions will be influenced by whether the child is living with parents/carers who are struggling to self-regulate or living with a parent or carer who has well-established self-regulation skills and is able to co-regulate others. In the situation of a child living with a parent/carer or returning to live with a parent/carer who does not have self- or co-regulation skills, there will also be a focus on what mechanisms for change are in play for the parent and what interventions can impact on those mechanisms.

The parent/carer may need to experience co-regulation through therapy or through enlisting extended family support. They may need to move to a new living environment that is calming. For example, if a parent/carer is living in a flat with holes in the walls and no heating or hot water, this will exacerbate any difficulties in self-regulation or their capacity to co-regulate others. If the parent/carer is living in a domestic and family violence situation she is not going to be self-regulated until she has a sense of, and reality of, safety. In this situation a primary emphasis for intervention will be to help cease or protect the family from violence, which may include working with or appropriately referring the parent perpetrating the violence.

Building capacity in parenting

As discussed in Section 6.1 on assessment and intervention planning and as illustrated in the example above, CPCS have a role in helping parents/carers to build their parenting capacity. This begins with an assessment of the child/young person and the parent/carers, and what is needed for change. Informed by this assessment, including identifying the mechanisms for change, particular interventions can be used by CPCS along with their colleagues in Family Preservation and Restoration services. Interventions that improve parent outcomes also improve child/young person outcomes (Macvean et al., 2015).

Additional messages from research to consider in building parenting capacity include the following:

- Approaches need to deal with parent/carer's underlying trauma as well as building skills and knowledge (Davies & Ward, 2012).
- Assessments need to identify which problems negatively impact parenting capacity, and target interventions to address these (Davies & Ward, 2012).
- Parents/carers with significant problems, such as mental health problems, substance use and dependence, and domestic ad family violence will need support to overcome these issues in addition to addressing the impact on their parenting (Frederico et al., 2014).
- Supporting parents/carers through change, especially when dealing with multiple complex issues, usually requires collaboration with a range of services, including specialist services such as alcohol and other drug, mental health and domestic and family violence programs (Frederico et al., 2014).

- Approaches should address multiple areas of parents' lives rather than any single issue. They should also support parent/carers' over time to allow parents to consolidate gains (Davies & Ward, 2012).
- Building capacity in parents/carers requires supporting and empowering them through collaboration and attention to their strengths, as well as an honest appraisal of any concerns (Fox et al., 2015).
- Assisting family members to discover their own resources 'however small' shifts the focus from problem finding to 'solution building' and allows the family to participate in finding and creating 'building blocks for change' (Edwards & Turnell, 1999, p. viii).

When planning interventions with parents/carers to strengthen their capacity to care and protect their children, it is worth considering the differences in therapeutic approaches when the goal is family preservation compared to family restoration. Some of the literature does not make this distinction, while others provide additional guidance when the focus is reunification. Examples of particular issues to take into account with family restoration include:

- Preparation of children, young people and families prior to reunification and through the transition process.
- Enlisting the carers as models, teachers, mentors and supports to the parents.
- Family-child/young person contact and how that can best be used towards furthering the areas requiring change to support the reunification goal.
- Some individual, dyadic, family and group work models available for families going through the reunification process (Jackson et al., 2014)

Appendix 11: Template to record Aboriginal cultural consultation

Child Protection Counselling Services (CPCS) consultation meeting template *(to record consultations)*

Client name:
Date and time of consultation:

Location/method:

Aboriginal Consultant:

CPCS counsellor:

Summary of family history/client experience provided to Aboriginal Consultant prior to consultation? Yes / No
Questions for Aboriginal Consultant:

1.

2.

3.

4.

5.

Responses/advice regarding questions:

Other recommendations

Sign	Sign
Aboriginal Consultant	Counsellor

Appendix 12: Aboriginal action plan template

Child Protection Counselling Service (CPCS) Aboriginal action plan template

CPCS service: Year:

Date to be reviewed:

Cultural competency	**Community engagement**
Goal: Aims: Steps to be taken: Outcomes: Coordinator:	Goal: Aims: Steps to be taken: Outcomes: Coordinator:
Aboriginal consultation	**Supporting the Aboriginal workforce**
Goal: Aims: Steps to be taken: Outcomes: Coordinator:	Goal: Aims: Steps to be taken: Outcomes: Coordinator:

Appendix 13: Aboriginal consultation cover sheet

Aboriginal consultation cover sheet
(to be placed on or near front cover of client file)

Client name:

CPCS counsellor name:

Date client commenced work with CPCS:

Client informed of availability of cultural consultation at first meeting? Yes / No

Initial consultation between CPCS counsellor and Aboriginal worker completed? Yes / No

Client's wishes for cultural consultation documented during assessment phase and a plan made to achieve these? Yes / No

1st consultation completed (assessment phase)? Yes / No

2nd consultation completed (intensive phase / 6 month review)? Yes /No

3rd consultation completed (closure phase) Yes / No

Incidental consultations completed:

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