



**REVIEW OF BEST PRACTICE  
IN RESIDENTIAL  
OUT OF HOME CARE  
APPENDICES**

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*The assistance of DSS Graduate Intern Jessica  
Groth with preparation of Appendices B and D  
is gratefully acknowledged*

SEPTEMBER 2019

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## APPENDIX A: HISTORY OF OOHC IN AUSTRALIA

The development of Australian child welfare systems began in the early 1800s when the New South Wales Government and a committee of private citizens established a home for orphans and destitute children, mostly of convict parents (Seymour 1988). Other colonies followed suit towards the middle of the nineteenth century. The second half of the nineteenth century witnessed the growth of reform and industrial schools to cater for both offending and destitute children. Attempts were made to classify and separate "criminal" and "neglected" youth. Reform and industrial schools were intended to contain and serve two, apparently distinct, juvenile populations: delinquents on the one hand and the merely destitute on the other. [...]

Church, state and charitable organisations were involved in the institutional control of these two groups of children, the state having primary responsibility for offenders, although it is clear that distinctions between the groups were blurred in practice. Towards the end of the nineteenth century growing concern about the use of large institutions resulted in the growth of community-based arrangements. "Boarding out" placements in foster homes began to replace industrial schools (Seymour 1988). The dual schools system was eventually abandoned but the uneasy relationship between welfare and so-called justice responses is still with us today.<sup>1</sup>

### OVERVIEW

In the period covered views about the purpose of OOHC, about the moral standing of poor parents and their children, especially unmarried or separated mothers, understanding of the developmental needs of children, and the conception of the rights to be accorded children, have undergone significant change. Nevertheless, many of the dilemmas remain.

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<sup>1</sup> Atkinson L (1994) [An overview of juvenile detention in Australia](#). In National Conference on Juvenile Detention, Edited by: ATKINSON, L. and GERULL, S. 1–27. Canberra: Australian Institute of Criminology, p3.

## INTRODUCTION: NOTE ON 'INSTITUTION'

*Residential* out of home care is *prima facie* distinct from care within 'institutions', which can refer to three related concepts:

- 1 a significant practice, relationship or organization in a society or culture
- 2 an established organization or corporation, especially of a public character
- 3 a facility or establishment in which people (such as the sick or needy) live and receive care, typically in a confined setting and often without individual consent.<sup>2</sup>

The history of 'institutional provision' of out of home care in Australia covers all three concepts – the practices and the cultures underlying them, the organizations providing care, and the facilities in which care is or was provided. However, residential OOHC, which refers to community-based care in small group homes that are open (i.e. residents cannot be restricted or confined), can certain characteristics of institutional care, discernible in the approaches, values and practices of the organisations providing it.

The move away from facilities-based care to residential care will be seen as part of the widespread process of deinstitutionalisation that gathered momentum in 1980's in Australia.

## SUPPORT FOR INDIVIDUALS AND FAMILIES IN THE AUSTRALIAN COLONIES

In her research paper on the history of institutional provision of OOHC in Australia, Swain (2014)<sup>3</sup> underlines the importance of understanding it in the context of support for the poor as it evolved separately within each of the early Colonies. She noted a common desire to avoid replication of the British Poor Laws,<sup>4</sup> which were inflexible in being tied to a local parish, had the potential to undermine wages for independent workers and were seen as creating moral hazards for recipients unless they were sufficiently low and obtainable only through the stigmatizing, and physically debilitating conditions of the workhouse.

Facilities for housing and supporting immigrants unable to support themselves and their families were gradually introduced – commencing with those run by subscription-based charities<sup>5</sup> – the Benevolent Society's Asylum in 1821, Melbourne's Immigrants'

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<sup>2</sup> Merriam Webster Dictionary, Accessed 23 April 2018 at

<sup>3</sup> Swain S (2014) [History of institutions providing out-of-home residential care for children](#). Research Report commissioned by Royal Commission into Institutional Responses to Child Sexual Abuse. ACU.

<sup>4</sup> The Poor Laws in force at the time of colonisation were less restrictive than those introduced after the Poor Law Commission of 1832- 1834, which recommended two principles: (1) less eligibility: the position of the pauper must be 'less eligible', or less to be chosen, than that of the independent labourer; and (2) the workhouse test: there was to be no relief outside the workhouse. See for example Paul Spicker: [British social policy, 1601-1948](#), excerpt from *British Social Policy in Theory & Practice*, 3<sup>rd</sup> edition, Policy Press, University of Bristol, 2014.

<sup>5</sup> Swain (2014) op. cit. Footnote 5, p. 5. 'A subscriber charity was a voluntary organisation controlled by a committee elected by subscribers, who were also entitled to a set number of 'tickets' each year which allowed them to recommend 'fit objects for relief'.

Aid Society in 1853. Governments in the smaller colonies assumed this function, with the South Australia's Destitute Asylum founded in 1849, and Western Australia's Immigrants' Home (later poor house) established in 1851.<sup>6</sup>

Settler children were accommodated within these institutions until the introduction of alternatives, all modelled on British exemplars.<sup>7</sup>

Most of the following is drawn from Swain's paper, which also provides information about those institutions that have survived in some form.

<sup>6</sup> See Swain op. cit. p. 5  
<sup>7</sup> Op. cit. p6.

## Orphanages and orphan asylums

Orphanages founded in both Britain and the United States from the late 18th century were voluntary organisations designed to rescue the children of the 'deserving' poor from being admitted to the workhouse.<sup>8</sup>

Australia's orphanages were mainly founded in the 19<sup>th</sup> century. Although some were established by governments (NSW, Tasmania, and Queensland) before being taken over by British style subscription charities, where they were run by local, non-denominational committees.<sup>9</sup>

These institutions were:

- Selective, with admission not necessarily based on need (e.g. taking few double orphans and selecting children of widows but not widowers);
- Largely closed to the outside world – family visits may have been permitted as seldom as once per month);
- Not free - relatives were expected to contribute to the costs of up-keep and visiting access may have been withdrawn from families in arrears; and
- Primarily for school age children, as infants and toddlers required more up-keep and had lower survival rates
- Self-contained with education, domestic tasks and farming undertaken in -house.
- Segregated by gender in accommodation and training activities from at least the age of 10, with girls engaging in domestic work and boys in indoor and outdoor work.
- Placed in charge of wages of former residents until they reached adulthood.<sup>10</sup>

The promise of the orphanage was that it provided for the children of the deserving poor, removing them from the stigma attached to lesser institutions, while training them to provide for themselves in the future. However, the type of care they offered was more about preparing them for their role as honest workers than restoring them to the status from which they had come.<sup>11</sup>

When residents without family to return to reached school leaving age they would be apprenticed in situations as domestic or agricultural workers where accommodation would form part of their wages.<sup>12</sup>

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<sup>8</sup> Ibid.

<sup>9</sup> Ibid.

<sup>10</sup> Ibid.

<sup>11</sup> Op. cit. p7

<sup>12</sup> Ibid.

## INDUSTRIAL SCHOOLS

A harsher form of institution – the industrial school – was adopted to accommodate children who failed to meet the admission criteria for the orphanages, having living parents who failed to care for them.<sup>13</sup>

The central idea underlying the notion of an industrial school was that such children, if left untrained, posed a risk in the future. It was thought that they would fall into the indolence, moral degradation or even criminality seen to be the cause of their family's poverty and produce another generation of 'paupers' dependent on government support. This risk was to be avoided by rendering the children industrious, teaching them the value of work and preparing them to support themselves in the future.<sup>14</sup>

The first industrial school opened in NSW in 1827, and following passage of enabling legislation, similar institutions accommodating children who were classed of wards of the state in most jurisdictions, were established in the other colonies (Vic 1865, Qld 1868, SA 1869, Tas 1877, NSW 1888, WA 1897)<sup>15</sup>.

These institutions:

- Accepted mainly school age children;
- Were separately established for boys or girls respectively in all colonies except Victoria, where they constituted the main form of care for state wards;
- Generally offered poorer quality education than orphanages, but offered training in domestic service for girls and farm work for boys, so as to provide access to a livelihood with accommodation;
- Generally permitted no contact with parents, although requiring parental contributions to for the maintenance of children;
- Discharged all residents to live-in work situations on the attainment of school leaving age, with the state being assigned custodianship of their wages until they reached adulthood.<sup>16</sup>

In all colonies except South Australia the industrial school model proliferated, with denominational providers entering the field, and some institutions surviving into the 20<sup>th</sup> century.<sup>17</sup>

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<sup>13</sup> Op. cit. p. 8

<sup>14</sup> Ibid.

<sup>15</sup> Ibid.

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

## DOMESTIC TRAINING HOMES FOR GIRLS

..the notion that poor children needed to be trained to be able to support themselves into the future had a longer lifespan, underlying two new forms of institution: domestic training homes for girls and farm training schools for boys. Both took in older children whose labour maintained the institution in which they resided [...] However, the type of training they were offered often related more to the perceived labour needs of the institutions' principal sponsors than to vacancies in the labour market which they entered on their discharge.<sup>18</sup>

The underlying philosophy of these residential homes was that training for work in domestic service would:

- equip residents to earn a livelihood;
- enable them to obtain situations with accommodation; and
- assist them to escape the lives of poverty and degradation of their families.<sup>19</sup>

Many of these institutions survived into the 20<sup>th</sup> century and some offered responded to the decline in demand for domestic labour by offering residents a chance to continue their education.<sup>20</sup>

## FARM TRAINING SCHOOLS FOR BOYS

These institutions developed later than the training homes for girls and they became more numerous, but their philosophy and conditions were analogous. Boys would be transferred to a training school at 9 or 10 and remain until the school leaving age of 14, when they would commence work on a farm.<sup>21</sup>

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<sup>18</sup> Op.Cit. p. 9

<sup>19</sup> Ibid.

<sup>20</sup> Ibid.

<sup>21</sup> Op.cit. p.10

The concept proved attractive to a range of sponsoring organisations, evidence of a widespread belief in the rehabilitative potential of rural labour [...] Farm schools were also used by child migration agencies to introduce British children to Australian life. [...] Although few of these institutions survived as working farms following the mechanisation of rural properties in the post-war period, the belief that troubled boys could be changed through exposure to rural conditions survived, with most such institutions continuing to offer a rural if not a strictly farming experience into the 1980s, and some new 'bush' or 'boot camp' programs in remote locations still being developed today.<sup>22</sup>

## CHILDREN'S HOMES

The term home was originally used in Britain by Evangelical Christians, eager to differentiate the institutions which they were founding from the 'barracks-style' institutions of the past. The word 'home' had connotations of the Christian family, in which the patriarchal father provided for his wife and family, safely ensconced in an environment imbued with love.<sup>23</sup>

The most common form of OOHC became 'the children's home', many of which commenced as one of the 'specialist' institutions already described.<sup>24</sup>

These institutions were:

- Generally, on a smaller scale than orphanages or industrial schools, although economic pressures favoured development of larger facilities where children would be grouped by age and sex rather than living in home-like circumstances;
- Originally funded on a private (parent, guardian or charity) subscription model, later supplemented by contributions from governments unable to provide sufficient foster care places; and
- Internally maintained, primarily by means of resident labour, with education provided in-house.<sup>25</sup>

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<sup>22</sup> Ibid.

<sup>23</sup> Op.cit. p.11

<sup>24</sup> Ibid.

<sup>25</sup> Op.cit. pp 11-12



## **FAMILY GROUP HOMES**

These institutions originated in post-war Britain. They too reflect a belief in the therapeutic value of family living for children needing OOHC.

In Australia this type of care:

- Was first introduced in Victoria in 1956;
- Has sometimes been offered by larger facilities who accommodated some residents in cottage housing;
- Is based on an ideal that has proven difficult to sustain in practice – that of geographically distributed homes that go unremarked in local neighbourhoods, and are staffed by married couples with their own children, where siblings can live as part of an extended family; and
- Breaks down when staff are replaced, and unrelated children replace school leavers those who have had to leave after completing school.<sup>26</sup>

...while the best of such facilities could come close to recreating a domestic family home, the worst perpetuated the risks of a family gone wrong, with children left isolated with no-one to whom they could report abuse.<sup>27</sup>

## **EMERGENCY ACCOMMODATION**

Doubts about whether children should be permanently rather than temporarily removed from families struggling to care for them resulted in a change of policy from the late 60's, facilitated by the availability of income support for single mothers.<sup>28</sup>

In this context, out-of-home care came to be imagined as a temporary necessity, the focus of which was to allow the family time to reform, rather than a long-term provision designed to fit the child for an independent self-sustaining future. Increasingly, the model was small units with rostered staff in which children could be placed within, where possible, their own community.<sup>29</sup>

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<sup>26</sup> Op.cit. p.12

<sup>27</sup> Ibid.

<sup>28</sup> Op.cit.p.14

<sup>29</sup> Ibid.

## **RECEPTION CENTRES**

These institutions were the forerunners of remand centres, being designed to accommodate juvenile offenders prior to court appearances, but they also accommodated children who were hard to place, or had failed placements, in foster care. They were intended to be short stay, but children with venereal disease, disability or chronic illnesses who were very hard to place could end up with long placements.

The familiarity of long-staying children with the institution meant that they often set its culture and took a leading role in the cleaning, caring and outdoor maintenance work that was the lot of all children in 'care'. In some extreme cases, such children spent their whole career in such centres, becoming part of the staff on reaching adulthood.<sup>30</sup>

The functions performed by these facilities were eventually replaced by remand homes (beginning in the early 20<sup>th</sup> century) and assessment centres (as psychological treatment entered the repertoire of care from the 1960's onward).<sup>31</sup>

## **SPECIALIST INSTITUTIONS FOR CHILDREN AND YOUNG PEOPLE**

### **FEMALE RESCUE HOMES**

These were primarily sponsored by religious organisations (or by charitable organisations run by individuals with religious affiliations) concerned to protect young women from moral danger. Residents might be placed in these institutions by child protection authorities after failed foster placements, by parents who had found them uncontrollable, or by the criminal justice authorities as an alternative to a fixed term in a correctional facility.

The aim of the institutions was to remove such young women from 'temptation', confining them behind high walls for indefinite terms, clothing them in dull, unadorned clothing and subjecting them to a diet of prayer and hard work, often in commercial laundries which provided the organisations' main source of income.<sup>32</sup>

### **MATERNITY HOMES**

These institutions, sometimes purpose built, sometimes stemming from reception centres or other OOHC facilities, catered for single mothers of all ages. Life for residents was in keeping with the social stigma attached to single parenthood. Residents entered late in pregnancy and after their offspring could survive without

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<sup>30</sup> Op. cit. p 15. Author recommends 'For a vivid recollection of this system in operation see: Walter Jacobsen, *Dussa and the maiden's prayer*. (Melbourne: Victoria Press, 1994).

<sup>31</sup> Ibid.

<sup>32</sup> Ibid.

them, unless marriage enabled immediate release. In the 20<sup>th</sup> century the stigma of birth out of wedlock increased, and there was strong pressure for separation of mother and baby upon birth, with the baby being put out for adoption. These homes survived until the 70's, when the shame attached to single parenthood declined sharply.<sup>33</sup>

## **BABIES' HOMES**

Before the development of safe infant formula mothers who could not look after their babies were obliged to place them with wet nurses. Reaction to the high death toll amongst babies so placed resulted in the introduction of babies homes – which were forced, in the interests of child health to cater for mothers at least until weaning, when the mother would be forced to leave but continue paying for the baby's upkeep.

In the 20th century, and particularly from the 1920s, new babies' homes were established to care for children destined for adoption. Adoption was made legal across the various states in Australia beginning in Western Australia in 1896. Eugenics-inspired doubts about the quality of children made available for adoption meant that demand immediately after the passage of the enabling legislation was low. Babies' homes were designed to address such doubts, keeping children for up to 18 months, during which time they were 'scientifically nursed' in order to overcome any possible problems.<sup>34</sup>

## **MOTHER AND BABY HOMES**

In some quarters the preservation of the relationship between mother and child was given priority and some single mothers were accommodated in homes for mothers and babies, where they could receive instruction on caring and providing for their child in the absence of a male breadwinner. Children would be sent into care where a mother was unable to earn a living. Religious bodies and voluntary organizations were in the main responsible for these institutions. Most disappeared with the 1980's deinstitutionalisation push, but at least one has survived.

## **REFORMATORIES**

...it is clear that juvenile detention has been a repository for the marginalised and the powerless.<sup>35</sup>

These gender segregated institutions were established to remove adolescents from the undesirable influence of prisons. Most residents were sentenced by the courts – youths considered at risk of a life of crime and adolescent girls a risk of moral offences

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<sup>33</sup> Op.Cit.p16

<sup>34</sup> Op.cit.p18

<sup>35</sup> Atkinson L (1994) [An overview of juvenile detention in Australia](#). In National Conference on Juvenile Detention, Edited by: Atkinson L & Gerull S.pp 1–27. Canberra: Australian Institute of Criminology.

– but some residents were children with behaviour problems that occasioned their removal from foster care.

Again, the model was British, although the first Australian institution, Point Puer<sup>36</sup> in Tasmania (1834), established as part of the convict system, predated England's first reformatory, Parkhurst, by four years. The other colonies quickly followed, Victoria establishing reformatories alongside its industrial schools from 1864, New South Wales in 1867, South Australia in 1869, Queensland in 1871 and Western Australia in 1881. The name of this new type of institution encoded the beliefs of its founders that, intercepted early enough, young criminals could be reformed. The regime varied little from the range of 19th century institutions that assumed prayer and hard work could transform juvenile offenders into honest workers. However, the struggle to contain the children and adolescents unwillingly confined to often overcrowded and poorly staffed institutions, created a space for both staff–resident and resident-on-resident violence.<sup>37</sup>

The Salvation Army and the Catholic Church persisted as the most prominent providers of reformatories in those colonies which permitted private institutions, but eventually all colonies followed the example of NSW in assuming government responsibility for juvenile justice.<sup>38</sup>

## HOSTELS

Gender segregated hostels were created to cater for the needs of older adolescents who had outgrown children's facilities, but still needed protected accommodation because they were either working for an employer who did not provide any, or were continuing their education.

The model dated back to the early years of the 20th century where it had been developed by churches and charitable institutions to provide protected accommodation, primarily for young women living alone in the city. It had also been used by governments, particularly in more remote areas, to provide supervised accommodation for adolescents pursuing secondary education. Many of the organisations running children's homes added hostels to their array of services in the post-war period. While young people who had grown up in 'care' were accommodated across the various types of hostels, most were sent to hostels associated with the institution from which they had come.<sup>39</sup>

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<sup>36</sup> 'There is a truly heart wrenching rendition of life at Point Puer in Marcus Clarke's novel *His Natural Life* (1970). Hughes gives a more restrained version in his book *The Fatal Shore* (1987).' From Atkinson L (1994) [An overview of juvenile detention in Australia](#). In National Conference on Juvenile Detention, Edited by: Atkinson L & Gerull S. pp 1–27. Canberra: Australian Institute of Criminology, p.2

<sup>37</sup> Swain (2014) op. cit. p 20

<sup>38</sup> Op.cit. p21

<sup>39</sup> OP.cit.pp21-22

## **YOUTH ACCOMMODATION**

The emergence of the smaller residential units, some same sex, some mixed, some with a therapeutic orientation, to accommodate children who could not be placed successfully in foster care, emerged in the 1970's.

From the 1970s both government and non-government organisations began to develop a new form of care for adolescents no longer able to be contained within foster care or family group homes, or more recently admitted to 'care' because of family breakdown or minor offending. These youth accommodation units house small groups of adolescents, some gendered, some mixed, supervised by rostered staff. Many were designed to have a therapeutic aspect, aiming to work with their residents to continue their education.<sup>40</sup>

However, many of those leaving this form of OOHC have encountered problems in transition to adulthood - some arising from the complex needs and behavioural problems associated with childhood maltreatment, some from the experience of OOHC itself, and some from social changes that have reduced the labour market opportunities for the least skilled.

...an increasing prevalence of mental illness and substance abuse has rendered this task challenging. With the collapse of the market for youth employment, the system struggles to find alternatives for young people whose educational experiences are poor and many such services attempt to extend eligibility well into early adulthood.<sup>41</sup>

## **DISABILITY INSTITUTIONS**

These facilities enabled children suffering from congenital disorders or the chronic effects of disabling illnesses such as polio, to be removed from asylums housing adults. Children with profound disabilities remain amongst the most difficult to protect, accommodate and treat in the OOHC system today. In colonial times they tended to be large facilities with low staff to resident ratios.

The earliest [disability institutions] established during the colonial era (WA 1857, Vic 1860, Qld 1865, SA 1874, NSW 1886, NT 1889, Tas 1898) were designed to remove children from the generic asylums, in the case of children with physical disabilities, and lunatic asylums for those with intellectual disability. Some of the new institutions were constituted as schools, designed to give their graduates skills through which they could become self-supporting in the future. For the more seriously disabled, and particularly the

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<sup>40</sup> Op.cit.p23

<sup>41</sup> Op.cit.p23

intellectually disabled, they were essentially seen as long-term options with little therapeutic input.<sup>42</sup>

## CONVALESCENT AND HOLIDAY HOMES

Convalescent homes existed outside the child protection regime and were subject to less stringent controls. Surviving models provide respite care for parents or carers, but they were originally developed to meet the needs of children recovering from debilitating illness.

Founded from the late 19<sup>th</sup> century, such homes were primarily the preserve of charitable or community organisations. Convalescent, sick children's and holiday homes offered temporary respite for small groups of children, usually based on a hospital model. Although most children were admitted to these institutions from their family homes, children in out-of-home 'care' could also be placed there. In jurisdictions with large foster care systems, state children's departments ran such institutions as well.<sup>43</sup>

## INDIGENOUS-SPECIFIC INSTITUTIONS – MISSION HOMES

Established from the early 19<sup>th</sup> century, missions were designed to accommodate children who were deemed to be orphans. However, an increasing proportion of residents were children whose parents lived on the mission, as well as children brought in from other communities. While, in principle, the children could still have contact with their parents and other members of their community, in practice, the assumption that adults were an obstacle to their children's progress meant that separation was increasingly enforced. Mission dormitories became the schools and homes that were central to the child removal policy, introduced in the late 19<sup>th</sup> century and spreading across the country in the 20<sup>th</sup> century.<sup>44</sup>

These Indigenous-specific institutions for children were often associated with assimilationist policies that motivated the child removal described in the Report on the Stolen Generations.<sup>45</sup>

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<sup>42</sup> Ibid.

<sup>43</sup> Op.cit.p24

<sup>44</sup> Swain S (2014) [History of institutions providing out-of-home residential care for children](#). Research Report commissioned by Royal Commission into Institutional Responses to Child Sexual Abuse. ACU. P27 Author notes that : 'The oldest listed so far opened in Western Australia in 1834. South Australia followed in 1851, the Northern Territory in 1877, Queensland in 1887 and New South Wales in 1893. They were most plentiful in the colonies and later the states whose substantial Indigenous communities provided a fertile field for missionaries. While some were short-lived, most survived into the second half of the 20th century when the move towards Indigenous self-determination saw them returned to local community control'.

<sup>45</sup> [Bringing Them Home](#) – the Final Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families (Australian Human Rights Commission, 1997)



## DEINSTITUTIONALISATION – THE NEED TO GET THE BALANCE RIGHT

Deinstitutionalisation began in Australia in the early 1970's and gathered momentum in the 1990's. Residential OOHC has been subject to deinstitutionalisation pressures around the world, so that a very small proportion of children in OOHC are now accommodated in residential facilities, and remaining facilities are smaller and more 'home-like'.

Many of the institutions described in the history above have survived in some form or other. However, the majority have changed in form or function since establishment. The process of deinstitutionalisation has affected all but the smallest residential facilities. It was prompted by accumulating evidence of abuses in closed institutions<sup>46</sup> and research that showed that, with some exceptions, people in need of prolonged care due to old age, illness, disability or, in the case of minors, the absence of appropriate family support, fared better if supported 'in the community', rather than in large scale, closed facilities.

Research presented in the main body of this report suggests that, provided certain safeguards are in place, facilities large enough to employ full time professional providers of therapeutic care may provide an OOHC environment that can promote the health and well-being of some children and young people with highly complex needs.

<sup>46</sup> As highlighted in (Burdekin B, Hall D & Gilfoyle M (1993) *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness* (AHRC) and yet again in the [Report of The Royal Commission into Institutional Responses to Child Sexual Abuse](#) (2017).

## **APPENDIX B - JURISDICTIONAL DIFFERENCES IN CHILD PROTECTION POLICIES**

**Acknowledgment** : Apart from brief updates on policy changes, this material is drawn from Appendixes C to E, 2016–17, Australian Institute of Health and Welfare, 2018

### **DIFFERENCES IN DEFINITIONS AND PRACTICE AFFECTING DATA COLLECTION**

Although implementation of successive 3-year action plans under the *National Framework for Protecting Australia's Children 2009-2020* have led to improvements in the comparability of data from different jurisdictions, substantive differences in legislation, policy and practice mean that there is further work to be done. The following remain impediments:

- Use of agency-defined and caller-defined approaches to recording notifications
- Thresholds used for risk assessment practices
- Treatment of multiple notifications and overlapping investigations
- Treatment of cases for unborn children, abuse in care, non-familial maltreatment and
- Where there is no suitable caregiver
- Care and protection orders issued, particularly for interim and temporary orders
- Reporting types of out-of-home care placements.<sup>47</sup>

The criteria for determining whether a notification is substantiated are not consistent across jurisdictions.

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<sup>47</sup> *Child protection Australia: Appendixes C to E, 2016–17*, Australian Institute of Health and Welfare, 2018, p1



## **NATIONAL DEFINITION OF OOHC NOT UNIFORMLY FOLLOWED IN NATIONAL OR LOCAL REPORTING**

The national definition depends on offered or actual payment for care:

Out-of-home care is overnight care for children aged 0–17 years, where the state or territory makes a financial payment or where a financial payment has been offered but has been declined by the carer.<sup>48</sup>

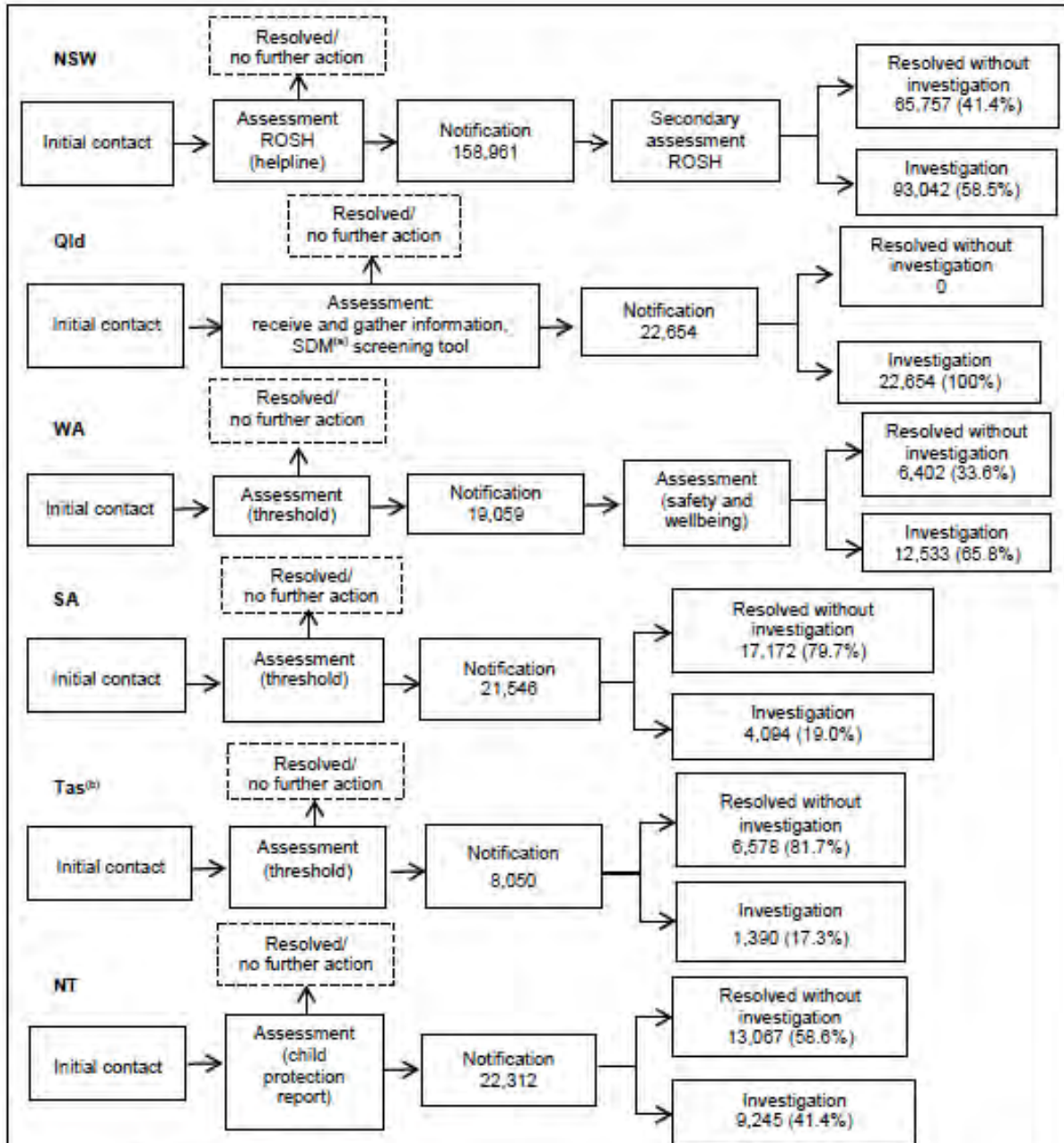
Jurisdictions differ in how they implement this definition locally and in national reporting:

- SA has used actual payment as the threshold;
- WA classes a number of situations as OOHC for local but not national reporting (hospital, other medical, unapproved placements, youth justice);
- TAS does not count children for whom a payment is made if they are not actually under a Care and Protection Order;
- ACT includes some over-18 year olds completing schooling whose carers still receive payment;
- In all jurisdictions emergency placement with relatives/kin is included in national reporting even prior to finalisation of assessment or payment authorisation.

<sup>48</sup> Op. cit. p.12

## DIFFERENCES IN THE CLASSIFICATION & PROCESSING OF CHILD PROTECTION NOTIFICATIONS

Differences between jurisdictions are represented in Figure C1: Agency-defined notifications, assessments and investigations.



(a) SDM stands for Structured Decision Making.

(b) From February 2016, notifications in Tasmania finalised under section 17(2)(a) of the *Children, Young Persons and Their Families Act 1997* (Tas) were classified as a child concern report, and were excluded from counts of notifications for the purpose of national reporting. As this change took full effect during 2016–17, the number of notifications reported nationally for Tasmania for 2016–17 has decreased compared with previous years.

Note: For some jurisdictions, the categories 'Resolved without investigation' and 'Investigation' do not sum to the total number of notifications as notifications in process have not been included in this figure.

Source: Table S5.

**Figure C1: Agency-defined notifications, assessment and investigations 2016–17**

## **THRESHOLD FOR INVESTIGATION OF A REPORT**

Jurisdictions differ in the use of thresholds for undertaking an investigation. In QLD all reports to the Department are subject to some level of investigation (hence 0% resolved without investigation). NSW and QLD employ a decision-making tool called Risk of Significant Harm tool (ROSH); in others 'risk of harm' - a potentially lower threshold may apply.

## **THRESHOLD FOR SUBSTANTIATION**

In some jurisdictions the threshold for substantiation depends upon action or inaction on the part of the parents; in others it depends upon assessment of actual harm.

Thresholds for what is substantiated vary—some jurisdictions substantiate the harm, or risk of harm, to the child, and others substantiate actions by parents or incidents that cause harm. In considering harm to the child, the focus of the child protection systems in many jurisdictions has shifted away from the actions of parents to the outcomes for the child.<sup>49</sup>

## **USE OF FAMILY SUPPORT SERVICES RATHER THAN STATUTORY CHILD PROTECTION**

Jurisdictions may vary in the use of family support services instead of statutory child protection.

Within the child protection system, there is a layering of risk, with suitable programs in place to support families and protect children, depending on this risk. At any point in the child protection process, children and their families may be referred to family support services which may be used instead of, or as a complementary service to, a statutory child protection response. For example, a service may provide parenting and household skills development, therapeutic care and family reunification services.<sup>50</sup>

## **TREATMENT OF FURTHER REPORTS ABOUT THE SAME CHILD**

Although all jurisdictions feed new reporting of a new event concerning the same child into the one investigation, in NSW, WA and the ACT it will be counted as a new notification, thus raising the level of notifications. The highest proportion of overlapping investigations occurred in SA (21%), the ACT (34%) and the NT(13%).

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<sup>49</sup> Child protection Australia 2016–17

<sup>50</sup> Op.cit.pp. 4-5

## **PRENATAL NOTIFICATIONS**

Legislation supporting prenatal notifications is present in all jurisdictions except SA and the NT. In 2016-17 just under 1700 such notifications were made.<sup>51</sup>

In jurisdictions where notifications for unborn children can be investigated (QLD, WA & TAS) pre-birth involvement usually consists of intensive work with the mother/family in an attempt to build support and divert the case away from child protection after the child is born. In Queensland, pre-birth work (including investigations where required) can only be undertaken with the consent of the mother.<sup>52</sup>

## **NO SUITABLE CAREGIVER – CLASSIFICATION AND DISPOSITION OF CASES**

- New South Wales, Victoria, South Australia and Tasmania report these cases as substantiated neglect.
- In Queensland, cases of ‘no suitable caregiver’ are reported as substantiated neglect if no other harm type was identified during the investigation and assessment.
- From 2015–16, in Western Australia, cases where the primary concern is ‘no suitable caregiver’ are outside the scope of national reporting.
- In the Australian Capital Territory:
- If the parent/guardian is unable to be found, the notification is recorded as neglect
- If the parent/guardian is deceased, the notification is recorded as ‘dealt with by other means’
- A notification is not recorded in some situations requiring substitute care. For example, a Youth Justice client using a diversionary program might be referred to another service without recording a notification.<sup>53</sup>

## **ABUSE IN CARE/EXTRA FAMILIAR MALTREATMENT – CLASSIFICATION & DISPOSITION OF CASES**

These cases are excluded from the data in SA and VIC but are reports are followed up by a separate process – e.g. in VIC they are followed up by close review of carer suitability and of provider performance and registration.<sup>54</sup>

A parallel review of care standards is also launched in QLD under s.122 of the *Child Protection Act 1999*, which defines the relevant standards, and where they have been

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<sup>51</sup> Op.cit. p.6

<sup>52</sup> Op.cit.p.8

<sup>53</sup> Op.cit.p10

<sup>54</sup> Op.cit.p9

breached and a child has been found to or suspected to have experienced harm, a Harm report will be made and, since 8 July 2013, a notification is recorded.<sup>55</sup>

In the NT since 2014-15:

all 'concerns about the safety and wellbeing of children in care' are reported and recorded as a child protection report and referred to an Internal Review Unit for a coordinated response. All matters that meet the definition of harm in the *Care and Protection of Children Act 2007 (NT)* are substantiated.<sup>56</sup>

See Table C7 below for summary of the classification and handling of these cases.

**Table C7: Recording of cases involving 'extra-familial maltreatment', states and territories**

Jurisdiction	Recorded in notifications, investigations, substantiations (not differentiated)	Recorded in notifications, excluded from investigations (dealt with by other means)	Recorded in notifications, investigated subject to conditions	Recorded in notifications, investigations, substantiations only where concerns relate to abuse in care	Recorded as case notes only where concerns relate to abuse in care
NSW	✓	x	x	x	x
Vic	x	x	x	x	✓
Qld	x	x	x	✓	x
WA	✓	x	x	x	x
SA	x	✓	x	x	x
Tas	✓	x	x	x	x
ACT	x	✓	✓	x	x
NT	x	x	✓	x	x

✓ Indicates the notification and investigation are recorded as per the description for the relevant category.

x Indicates the notification and investigation are not recorded as per the description for the relevant category.

## Children on third-party parental responsibility orders

Jurisdictions differ in their treatment of children who have been consigned to the care and responsibility of a third party by the Court - in whether they are counted in national reporting of OOHC, and in the degree of supervision/management and payment arrangements.

<sup>55</sup> Ibid.

<sup>56</sup> Ibid.

## RECENT POLICY REFORMS BY STATE/TERRITORY

[based on Appendix D AIHW Child Protection Australia 2016-17 with updates]

### NEW SOUTH WALES (NSW)

**Summary:** Under the new policy, residential OOHC will be restricted to emergency placement and as short-term measure to stabilise children and young people with complex needs that make them unsuitable for home-based care. After assessment and temporary placement in residential OOHC the child would be offered evidence based therapeutic interventions and his/her family would be offered therapeutic interventions and/or support. The aim would be to achieve safe reunification with family or permanent placement (kin/relative or foster) within two years. The child would have power of veto over any permanent placement proposal.

The NSW Government has committed \$1.9 billion in June 2017 to protect and support NSW's most vulnerable children, young people and families—a 13.4% increase on 2016–17. The funding supports a significant reform agenda that will help improve the lives of vulnerable children and families.

Their Futures Matter is the centrepiece of this agenda. Announced in early 2017, it sets out the long-term vision for child protection and wellbeing in NSW.

Their Futures Matter aims to build an accountable system in which client outcomes, strong evidence and targeted services are delivered based on client need, premised on an unprecedented level of collaboration across government.

Specific features of the reform include:

- Applying an investment approach to service design and delivery to guide investment, target responses and ensure an evidence-focused system
- Using data to identify the most vulnerable groups so their needs can be prioritised, and services provided earlier and in ways that will work
- Introducing child and family-centred cohort support packages to ensure vulnerable children and families get access to the services they need
- Aligning cross-government funding for vulnerable children and families
- Establishing a single commissioning entity that will be responsible for ensuring commissioned services are coordinated, evidence-based and driven by the needs of children and families.



Their Futures Matter is currently heavily invested in family preservation and restoration programs. It has commissioned a trauma treatment service to provide targeted, evidence-based interventions to decrease trauma symptoms (including as a result of domestic and family violence) and improve psychological wellbeing for children in OOHC. As part of the service, two multidisciplinary teams (based in greater Newcastle and Penrith) will work with up to 150 children and young people in foster, relative and kinship care per annum.

Each year 900 places are available for intensive family preservation and restoration services — Multisystemic Therapy Child Abuse and Neglect (MST-CAN®) and Functional Family Therapy Child Welfare (FFTCW®) — aimed at keeping families together. Half of these places are for Aboriginal children and their families. MST-CAN and FFT-CW provide intensive home-based clinical therapeutic treatment and have a proven record of success in addressing the underlying causes of trauma, including domestic and family violence, that results in harm to children, young people and families. Further expansion of these models will depend on the evaluation and outcomes of the current rollout, as well as consideration of demand and impacts of the TFM reform.

Their Futures Matter will be implementing a pilot of MST-Intimate Partner Violence (IPV) in two sites in 2018, which focuses on child protection concerns and addresses intimate partner violence.

As part of the 2018 Their Futures Matter work plan, evidence-based interventions will be implemented to support placement stability support services. In addition, work is already underway regarding aftercare services. An evidence-review is being completed to inform the development of a model of care, practice framework and funding mechanism.

An important step towards Their Futures Matter is the Permanency Support Program, a series of changes from October 2017 to shift from a 'placement-based' service system to a child- and family-centred service system that focuses on individual need, helping families to change and achieving permanency for children and young people soon after they come to the attention of the child protection system.

In the new system, every child or young person will have a case plan with a goal for permanency within two years of entering care.

Case plans will be focused on working with families to keep children at home or find a stable and secure option through guardianship or open adoption (unless the child is Aboriginal).

Under the Permanency Support Program, the NSW Government has changed how it funds non-government partners. New performance-based contracts support intensive

work with children, families and carers to achieve a safe and stable home for vulnerable kids.

As part of this reform, new contracts for care of the most vulnerable young people will be introduced in 2018. This will require providers to deliver therapeutic care for young people aged over 12 who are unable to live with their family or carers.

The Permanency Support Program has four main components:

- 1 Permanency and early intervention principles built into casework:**  
In the new system, a child or young person will have a case plan with a goal for permanency within two years of entering care. There will be a number of funding packages and targeted support packages that can be mixed and matched to suit a child or young person's individual needs and achieve case plan goals.
- 2 Working intensively with birth parents and families to support change:**  
By reducing the number of children in out-of-home care, funds can be re-invested in the delivery of family strengthening and prevention services to strengthen the capacity of families to care for their children. This will create a stronger and more innovative service system in the longer term.
- 3 Foster carer recruitment, support and retention:**  
A new carer recruitment and retention strategy with new providers will be introduced in 2018. It aims to address shortages, and recruit foster, kinship and relative carers who would like to support restoration or become adoptive parents (unless the child or young person is Aboriginal).
- 4 Intensive Therapeutic Care system reform:**  
The government will keep a strong focus on recovery from trauma through an Intensive Therapeutic Care system for children over 12 years who have been assessed as requiring intensive therapy. Intensive Therapeutic Care will be introduced to replace residential care.

Their Futures Matter and the Permanency Support Program builds on the success of early reforms including Safe Home for Life reforms and the transition of children in out-of-home care to non-government organisations.

The Safe Home for Life reforms, introduced in 2014, strengthened the child protection system through legislative change, new policy and practice and a redesign of how technology is used in child protection. Permanency placement principles and Guardianship orders were introduced for the first time and there was a renewed focus on open adoption. In 2016–17, 129 children were adopted from out-of-home care, by



far the highest number of any state. New South Wales also has over 2,500 guardians and over 95% of Australia's out-of-home care open adoptions.

Close to 58% of children in out-of-home care are now managed by non-government organisations. The transfer of children began in 2012 in recognition of the fact that non-government organisations are more flexible and closer to the community, allowing them to implement reform and innovative service models more quickly than government agencies.

The reforms complement the NSW Government's work to intervene early in the life of a family and prevent children from coming to the attention of the child protection system. The NSW Government invests \$95 million for Targeted Earlier Intervention to provide parenting, youth and family support programs and, \$65 million for community development and strengthening programs. The NSW Government is building a system that is flexible, responsive to local needs and strengths, and is evidence-based and client-centred.

In September 2018, the Children and Young Persons (Care and Protection) Amendment Bill was introduced in the NSW Parliament. Changes outlined in this bill will have a significant impact on the child protection system, including:

- Placing a two-year limit on creating a permanent arrangement for a child
- Making guardianship orders by consent outside of courts
- Amending how families can apply for restoration
- Removing parental consent to adoption for children on permanent orders.

## **AUSTRALIAN CAPITAL TERRITORY**

A key priority for the Australian Capital Territory Government is to maintain and continually improve a responsive and high-performing child protection and out-of-home care system. Reforms are being progressed under the banner of 'Refreshing the Service Culture'. The change agenda incorporates strategies to implement recommendations from reviews that the Australian Capital Territory Public Advocate undertook in 2011 and 2012 and the Australian Capital Territory Auditor-General's performance audit in 2013. These include:

- Progression of the development of a 5-year Out-of-Home Care Strategy, A Step Up For Our Kids, to guide the purchase and delivery of out-of-home care services from July 2015 to June 2020. The main aim of the strategy is to ensure the supply and quality of out-of-home care placements for children and young people in the care of the Director-General
- Improved services and supports for kinship carers, including engaging specialist services to provide therapeutic services for children, young people and carers in their care environment

- Enhanced early intervention services and supports for pregnant women, as well as for young people, through the implementation of case conferencing
- A strengthened approach to developing cultural plans that are relevant and meaningful for Aboriginal and Torres Strait Islander children and young people in care
- Implementation of Child and Youth Protection Services (CYPS) from July 2015, providing integrated care and protection and youth justice case management.

In July 2016, the ACT Government announced Carers ACT as the provider for the new Advocacy Support Service for foster and kinship carers. This change is part of the Step up for our Kids strategy. The Advocacy Support Service for foster and kinship carers commenced in August 2016.

## **VICTORIA**

Victoria's legislative foundation for child protection is provided by the Children, Youth and Families Act 2005, Child Wellbeing and Safety Act 2005 (which is the framework legislation for services for all children) and the Commission for Children and Young People Act 2012, which established an independent commission for children and young people.

The Children, Youth and Families Act, which commenced operation in April 2007, provides a unifying framework for:

- Family and placement services that community service organisations deliver
- Child protection services that the Department of Health and Human Services delivers
- Decision making by the Children's Court.

The Act explicitly places children's best interests at the heart of all decision making and service delivery.

The Commission for Children and Young People Act established an independent commission to promote continuous improvement and innovation in policies and practices relating to the safety and wellbeing of vulnerable children and young people, and of young people generally, and in the provision of out-of-home care services for children.

The Department of Health and Human Services works in partnership with community service organisations and Aboriginal services to strengthen support services for vulnerable families. Strong focus is given to keeping Aboriginal children connected to their culture and community.

The department is currently in the process of working with Aboriginal organisations to develop the policy model and service capacity to enable the transfer of responsibility

for Aboriginal children subject to court orders from the Secretary to the principal officer of an Aboriginal organisation under section 18 of the Act.

Although front-end child protection demand has exhibited real growth in recent years, the enhanced availability of diversionary services, especially through referrals to Child FIRST (Child and Family Information, Referral and Support Teams), has meant that the number of children subject to court orders has remained relatively stable.

A new child protection operating model, set out in *Protecting children, changing lives: a new way of working* (Victorian Department of Human Services 2012) commenced in November 2012. It aimed to achieve the following outcomes:

- A more experienced and skilled workforce
- Better supported staff benefiting from more supervision, co-working and mentoring
- Putting case practice at the centre of work with children, young people and families
- Reduced case transitions and devolved decision making to better support outcomes
- Improved career pathways and staff retention.

Under the model, child protection is delivered through 4 divisions consisting of 17 child protection areas across Victoria that are aligned with local Child FIRST catchments.

The Children, Youth and Families Act 2005 was substantially amended in March 2016 to explicitly promote the achievement of permanency planning objectives (family preservation, family reunification, adoption, permanent care, long-term out-of-home care) for children in need of protection. The amendments included a new range of protection orders and changes to case planning requirements and included stronger timelines consistent with the achievement of those objectives than had existed previously. The impact of these significant amendments was subject to an inquiry by the Commission for Children and Young People.

Consistent with the government and departmental policies regarding self-determination, the gradual transfer of responsibility for Aboriginal children and young people on protection orders from community service organisations and the department to Aboriginal Community Controlled Organisations has commenced.

Additionally, Victoria is implementing a range of recommendations arising from recent inquiries conducted by the Commission for Children and Young people which include improving compliance with the Aboriginal and Torres Strait Islander Child Placement Principle and cultural support planning. The department's 'roadmap for reform' is developing area-based and pro-active service provision of all community services to local communities, and this will have an impact on the future role and scope of the child protection program which currently performs many tasks more appropriate to secondary rather than tertiary/statutory services. This strategy incorporates

responses to a wide range of recommendations made by Victoria's Royal Commission into Family Violence.

Victoria has also announced their support of the Home Stretch Campaign, thereby extending the leaving care age to 21 years.

## **TASMANIA**

Tasmania is delivering an integrated system for child wellbeing and safety as system with an additional investment of over \$20.5 million.

Early intervention is central to the Strong Families - Safe Kids Implementation Plan 2016–2020, demonstrated by initiatives such as:

- The implementation of a new, state-wide advice and referral service
- Embedding an amplified wellbeing paradigm into child and family practice
- Strengthening the partnership and collaborative approach to interventions across Child safety services, other Government agencies and community services
- Providing further investment in assertive family support that can help keep at risk children safely with their families.

In turn, this enhanced focus on strength and resilience will allow child safety teams to provide a more targeted, team-based response to child safety concerns.

Significant work to progress this massive reform agenda occurred during 2016–17.

Additional support has been injected into the child wellbeing and safety system with the recruitment of new positions that are supporting intensive family engagement, clinical practice consultants, support workers and hospital liaison.

Central to the early intervention approach is the promotion of child and youth wellbeing. The foundation document, The Child and Youth Wellbeing Framework has been progressed in conjunction with a cross-sectoral committee. It provides a common definition of wellbeing.

This is the first step in work that will help education the Tasmanian community about the definition, importance and strategies for building wellbeing.

Consultation commenced with child safety staff and stakeholders on the redesign of the child protection system that will establish Tasmania's single front door.

Substantial work on out of home care occurred during the period.

The Strategic Plan for Out of Home Care in Tasmania was released in March 2017 in response to the Commissioner for Children and Young People's report Children and Young People in Out of Home Care in Tasmania. The Strategic Plan outlines a positive way forward that, with sustained long-term effort, will contribute to the delivery of better outcomes for children and young people requiring short, medium or long term care away from home. It continues previous work to reform the out of home care

system that had focussed on specialised care services— sibling group care, residential care, therapeutic services and special care packages for children with an extraordinary need for care.

The Strategic Plan articulates five key strategies that form the basis of improvement to the out of home care system. They are reflective of the prevailing themes contained within previous inquiries and reports into both the child safety and out of home care systems and align with national standards and efforts. They are:

- 1 Leading an accountable system
- 2 Defining and delivering quality care
- 3 Building the out of home care system
- 4 Delivering a safe out of home care system
- 5 Improving outcomes for children and young people in out of home care.

The out-of-home care foundations project was also established, focusing on the quality, standard and accountability of out-of-home care provided in Tasmania. During the reporting period, the initial output, an outcomes framework was drafted and consultation with service providers, carers and children with an out-of-home care experience commenced.

Amendments to the *Children, Young Persons and Their Families Act 1997* in 2013 reflected the Tasmanian Government's response to the recommendations of the Legislative Amendment Review Reference Committee (LARRC), established by the previous government to advise on the Principal Act. The committee provided a detailed report on the need for amendments to some 21 areas of the Act including detailed advice on the preferred policy direction to support the amendments. The amendments are aimed at a less adversarial way of working with families, which aligns and supports the Signs of Safety approach.

Extensive work was undertaken for proclamation of 2 rounds of legislative amendments relating to the *Children, Young Persons and Their Families Amendment Act 2013* on 1 July and 1 October 2016.

- The key changes of the 1 July 2016 amendments included greater recognition of the family as the preferred environment for the child or young person, a clear outline of the responsibilities of government in safeguarding the wellbeing of children and young people, and the strengthening of the principals of the Act by expanding the 'best interests' of a child or young person.
- The 1 October 2016 amendments to the Act provided increased safeguards to ensure that decisions made about children and young people by the court are based on reasonable grounds and in the child or young person's best interests.

The Advocacy for Children in Tasmania Committee (ACTC) was established as a result of one of the LARRC recommendations to conduct a second-stage process to clarify the expectations of the role, function and powers of the Commissioner for Children. The ACTC made 15 recommendations relating to advocacy services for Tasmanian children, including the function and role of the Commissioner. One of these recommendations was the development of standalone legislation.

The Commissioner for Children and Young People Act 2015 commenced on 1 July 2016, providing the Tasmanian Commissioner for Children and Young People with functions and powers consistent with the recommendations of the ACTC. The Act establishes the position of the Commissioner, clarifies the functions, and strengthens the powers available. The Act establishes the functions of the Commissioner as including systemic advocacy and the ability to undertake own motion enquiries relevant to the functions of the position. Importantly, the Act enables the commissioner to gather the information needed to undertake the functions of the position and the commissioner has discretion as to how those functions are performed.

Tasmania has also announced their support of the Home Stretch Campaign, thereby extending the leaving care age to 21 years.

## **QUEENSLAND**

In response to the 2013 Queensland Child Protection Commission of Inquiry report Taking Responsibility; A roadmap for Queensland child protection, changes to the child protection system were introduced. In April 2016 Supporting Families Changing Futures: advancing Queensland's child protection and family support reforms was released to outline achievements to date, prioritise actions and new initiatives. (Queensland Department of Communities, Child Safety and Disability Services 2016). A 12-month progress report of the reform program was released on 10 October 2017 (Queensland Department of Communities, Child Safety and Disability Services 2017b).

Over 10 years, the Supporting Families Changing Futures reform program will build a new support system for children and their families that will have a greater focus on supporting families to provide a safe and secure home for children. Families will receive support earlier to care for their children, and the capacity of the non-government service sector will be increased to provide more of the services that vulnerable families need.

The reforms encourage everyone in the community to take responsibility for protecting children and place appropriate responsibility on each government department providing human services to take responsibility for whole-of-government outcomes for children. Ongoing and successful implementation has required a fundamental shift in the way government agencies, child safety professionals and community organisations work with vulnerable families, and with each other.

Queensland has completed its third year of implementing its Supporting Families Changing Futures program, which is focused on building the family support service to support families earlier and restoring and improving the tertiary child protection system. As at 30 June 2017, Queensland focused on:

- restoring frontline child safety services and employing additional staff
- tackling growing demand and complexity, especially due to the impacts of 'ice' and domestic and family violence
- growing investment in prevention and early intervention services
- improving engagement and support for children in out-of-home care and their carers
- acting on the learnings and recommendations from reviews
- delivering better performance in the tertiary child protection system.

As part of the Supporting Families Changing Futures reform program, the Department of Communities, Child Safety and Disability Services completed a comprehensive review of the Child Protection Act 1999, including extensive public consultation. Through these consultations, it was found that while Queensland's child protection legislation was generally operating well, priority amendments and opportunities for broad legislative reform were identified. On 26 October 2017, the Child Protection Reform Amendment Act 2017 was passed in the Legislative Assembly and assented to on 10 November 2017.

The Child Protection Reform Amendment Act 2017 aims to:

- promote positive long-term outcomes for children in the child protection system through timely decision making and decisive action towards either reunification with family or alternative long-term care
- promote the safe care and connection of Aboriginal and Torres Strait Islander children with their families, communities and cultures
- provide a contemporary information sharing regime for the child protection and family support system, which is focused on children's safety and wellbeing, and
- support the implementation of other key reforms under the Supporting Families Changing Futures program and address identified legislative issues.

Recognising the need to work fundamentally different and to eliminate the disproportionate and growing representation of Aboriginal and Torres Strait Islander children and families in the child protection system, the Queensland Government, in collaboration with Family Matters, released Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families 2017–2037 in May 2017, and the first three-year action plan, Changing Tracks, to realise this strategy. The action plan builds on existing initiatives and includes new actions guided by Elders, community leaders, community run organisations, peak bodies and relevant

government agencies (Queensland Department of Communities, Child Safety and Disability Services 2017a).

As part of the Child Protection Reform Amendment Act 2017, the amendments to the Child Protection Act 1999 have commenced in stages over 2018.

Stage one amendments (implemented on January 2018), allow more information to be provided to:

- people who are, or have been, living in care
- a parent or guardian, if a deceased child was subject to a child protection order
- the police, if an investigation is being conducted following a child's death
- child welfare authorities in other jurisdictions to respond to child protection concerns.

The second stage of amendments commenced on 23 July 2018, with changes made to:

- Vaccinations
- Intervention with Parental Agreement
- Temporary Custody Orders
- Research
- Child witness protections
- Use of Information by the Queensland Police Service.

The third and final stage of amendments commenced on 29 October 2018, including:

- The safe care and connection of Aboriginal and Torres Strait Islander children with family, community and culture including the right to self-determination and embedding of the Aboriginal and Torres Strait Islander Child Placement Principle in legislation, removal of reference to the Recognised Entity, introduction of the new concept of an independent person for a child or young person, and the ability to delegate functions and powers to an Aboriginal and Torres Strait Islander organisation.
- Supporting Permanency and Stability for children, now and throughout their lives including introduction of a new permanency framework to promote timely decision-making, greater emphasis on all dimensions of permanency — relational, physical and legal aspects, stronger focus on achieving permanency goals and concurrent case planning, limitations on the use of consecutive short-term orders and the introduction of the permanent care order.
- A contemporary information sharing framework including a greater ability for the family support system to share information and the publication of an Information Sharing Guideline by the Department of Child Safety, Youth and Women.



- Transition to Adulthood including a legal requirement for transition planning to commence from 15 years of age and the extension of support eligibility up to the age of 25 for young people who have been in care.

## **NORTHERN TERRITORY**

On 8 September 2016, the Northern Territory Government announced changes to improve service delivery for families. This included the creation of Territory Families as a Government agency with responsibility for the portfolios of care and protection, youth justice, youth affairs, multicultural affairs, seniors, and senior and pensioner concessions, domestic and family violence, gender equity and diversity, and children's policy.

These frontline and advocacy portfolios were consolidated into one agency to enable a focus on a whole-of-life approach to supporting families. Territory Families' establishment has created an opportunity to deliver holistic services that result in positive outcomes across the breadth of social issues that impact on Territory families.

Throughout 2016–17, Territory Families staff have worked to build a new agency focused on delivering systemic improvements to the portfolios and programs for which we are responsible. This has included establishing many of the foundations necessary for any new agency. A key priority has been the development of a new organisational structure to best reflect the responsibilities of the agency, and a regional service delivery framework that supports local decision-making, backed by a global budget model.

Operational improvements are focused on support for children and their families through the delivery of a diverse, yet connected, range of frontline services that focus on more than statutory intervention. The aim is to place child protection and youth justice services within a broader framework of programs for prevention and early intervention and provide better support for families when they need it.

This has occurred in the context of responding to shortcomings within our systems, including those identified by the Royal Commission into the Protection and Detention of Children in the Northern Territory.

On 26 July 2016 the Commonwealth Government announced the establishment of the Royal Commission into the Protection and Detention of Children in the Northern Territory (the Royal Commission). The Royal Commission was established in response to concerns about the treatment of children and young people in the child protection and youth justice systems in the Northern Territory.

The first public hearings for the Royal Commission were held in Darwin on 11–13 October 2016. On 31 March 2017, the Royal Commission handed down an interim report, which identified key themes of the Royal Commission, however did not put forward any recommendations or findings.

Throughout 2016–17, Territory Families worked with non-government organisations to develop a new model of early intervention services and to reform the family support service system. The purpose of the family support system reform is to shift away from an approach of crisis management to one of providing early support for children and their families.

As part of the family support system reform, new ongoing funding was committed to establish an alternative referral pathway to connect families to family and parenting support services at the community level without direct involvement in the statutory child protection system. This pathway is one aspect of a suite of services and frameworks to be developed over a phased approach to invoke meaningful change for children and families early on by ensuring they have access to the appropriate advice and assistance before harm occurs.

In February 2017, the Northern Territory Government signed the Family Matters Statement of Commitment developed by the Secretariat for National Aboriginal and Islander Child Care. This statement commits to the intent to work with Aboriginal and Torres Strait Islander peoples and their organisations to deliver better responses to children and families within the child protection system. The Statement of Commitment commits Territory Families to six core principles which will guide the improvement and reform of the child protection system.

In recognition of the valuable role of Aboriginal organisations in delivering services to Aboriginal families, Territory Families began working with non-government organisations to plan the transition of out-of-home care services to the non-government sector, with a primary focus on increasing the involvement of Aboriginal community-controlled organisations in the provision of care. Territory Families engaged the Aboriginal Peak Organisations of the Northern Territory to design and deliver an out-of-home care system where more Aboriginal children are cared for by Aboriginal carers, and where connection to culture and identity is strengthened. The Secretariat of National Aboriginal and Islander Childcare has also joined this partnership with a specific focus on the Central Australia region.

Territory Families also commenced work to introduce an out of home care auditing and accreditation system to ensure all residential care facilities are providing quality care outcomes for each young person in their care, are responsive to local needs and that Aboriginal organisations and other non-government organisations with relevant experience and expertise in the Northern Territory are not disadvantaged.

On 26 May 2017, the Northern Territory Charter of Rights for Foster and Kinship Carers was launched as part of Territory Families' commitment to improving its partnership with foster and kinship carers. The Charter was developed in consultation with foster and kinship carers and other key stakeholders and solidifies recognition of the valuable role that foster and kinship carers play in ensuring children are safe and protected from harm.

## **SOUTH AUSTRALIA**

The Child Protection Systems Royal Commission conducted a comprehensive investigation into the laws, policies, practices and structures in place for children at risk of harm, including those who are under guardianship of the minister.

The report, *The Life They Deserve* was delivered to the Governor of South Australia on 5 August 2016 and described a system in urgent need of reform. In the report, Royal Commissioner Nyland made 260 recommendations for improvements to the child protection system.

The government's response to the Royal Commission's findings, *Child protection: a fresh start* was released 29 November 2016 (Attorney-General's Department, Government of South Australia 2016). A fresh start aims to improve outcomes for vulnerable children, their families and the broader South Australian community by proposing extensive improvements to our state's child protection system.

The report responds to each of the recommendations from the Child Protection Systems Royal Commission, but also goes further to develop a broader system response to vulnerable children and families.

Governance is led by the Child Protection Reform Portfolio Management Board (PMB). This is a cross-government agency body reporting to Cabinet and the PMB is supported by two key groups:

- The Aboriginal Community Leadership Reference Group (ACLRG) represents, advocates for and advises on the needs of Aboriginal children, young people, families and communities to ensure voices are heard and views are embedded in the implementation of reforms and wider system initiatives.
- The Child Safety and Wellbeing Advisory Panel (CSWAP) are key non-government and government child protection agencies who are seeking improved outcomes for children and young people. The CSWAP contributes to the implementation of child protection system reforms through the provision of expert advice to Government ministers, key partners, governance groups and implementation teams.

The Department publishes progress reports on implementation of the recommendations. The December 2017 progress report is available at [www.childprotection.sa.gov.au/department/a-fresh-start/recommendations](http://www.childprotection.sa.gov.au/department/a-fresh-start/recommendations)

A number of key achievements have been realised. These include:

- The establishment of the Department for Child Protection in November 2016.
- Establishment of a reformed call centre to better receive, record and refer notifications of alleged abuse or neglect.
- Call centre reforms are part of the Child Safety Pathway initiative that has established a Multi-Agency Assessment Unit (MAAU) to ensure an integrated

cross-agency approach to sharing information and responding to allegations of child abuse and neglect. The aim of the program is to broaden referral pathways and provide an earlier response for families, preventing matters from escalating to the point of statutory intervention. The MAAU is aimed toward children from pre-birth to 2 years of age (first 1000 days). By focusing on children earlier in their life, the MAAU serves as an opportunity to provide a coordinated cross-agency response, including as a referral pathway to Child and Family Assessment and Referral Networks (CFARNs).

- Child and Family Assessment and Referral Networks (CFARNs) are being piloted to support a local community cross agency response. CFARNs provide a local entry point to services from partner agencies in the region, focusing on collaborative practice and coordinated, multi-service responses.
- An Early Intervention Research Directorate (EIRD) has been established in the Department for the Premier and Cabinet. EIRD will develop new early intervention strategies to better support vulnerable families and to ensure intervention programs are effective, with a specific focus on Aboriginal children and families.
- The position of Commissioner for Children and Young People has been established and appointed.
- A new Child Protection Service (CPS) has been funded to be established at the Lyell McEwen hospital. The CPS provides specialist assessment and treatment services to children from birth to 18 years and their families where there is a suspicion of child abuse, psychological maltreatment and/or neglect.

The *Child and Young People (Safety) Act 2017 (Safety Act)* was passed in Parliament in July 2017. The Safety Act implements several recommendations of the Royal Commission and will provide the legislative framework for much of the child protection reforms across government and the community. The legislation will commence in two stages— the first stage in February 2018 and then full commencement in October 2018.

The first stage prioritises child focused practice including a stronger voice for children, greater rights for approved carers, assistance for care leavers, oversight of our care environment for children and young people, additional functions of the Minister and the Chief Executive, improved information sharing, and greater oversight of decision making. The Safety Act will drive transformational change to the child protection system and the way the Department for Child Protection, non-government service providers and all government and system partners operate to ensure vulnerable and at-risk children and young people are kept safe.

The Department for Child Protection continues to strive to improve the outcomes for Aboriginal and Torres Strait Islander children and young people in out-of-home care.

The Aboriginal Cultural Identity Support Tool (ACIST) was introduced in 2016. This has been developed by the Department for Child Protection to better support how

children will maintain their connection to family, country, community and culture. ACIST is developed in partnership with children's extended family and community where appropriate. As part of the implementation of the new Safety Act, the ACIST will become part of accepted case management.

An Aboriginal recruitment and retention strategy is being developed to increase the department's Aboriginal workforce. A Director, Aboriginal Practice position has been created to lead practice relating to Aboriginal children and young people.

The Aboriginal Impact Statement (AIS) was introduced in 2016. The AIS accompanies the development of any significant policy and practice change to strengthen culturally responsive policies, practices, initiatives, contracts, and agency reforms and to ensure that any impacts on Aboriginal business have been considered.

The Department for Child Protection remains committed to driving down placements of children with commercial care providers. Progress is reported on the DCP website [www.childprotection.sa.gov.au/departments/reporting-and-statistics](http://www.childprotection.sa.gov.au/departments/reporting-and-statistics) and shows consistent reduction of numbers of children placed in these facilities. From 30 June 2016 to 31 December 2017 placements have reduced from 190 to 84.

Initiatives to increase family-based care and improve placement stability for children in out of home care, include:

- Other Person Guardianship, which transfers legal guardianship from the Minister to carers, giving the carer increased rights, responsibilities and decision-making powers
- Family Day Care, where a professional carer looks after children in their home
- the Family Scoping Unit, a dedicated team to research family connections and prepare genograms for Aboriginal children and young people
- provisions in the Children and Young People (Safety) Act 2017 that increase the rights and recognition of carers.

Consistent with a whole of systems approach, the South Australian government as part of the machinery of government changes to establish the new Department for Child Protection, established stronger alignment of early childhood development and protective strategies with the Department for Education and Child Development. This includes the Child Wellbeing Practitioners program, a schools-based program to provide early intervention and support for vulnerable children and their families.

A new Disability Program has been established in response to Royal Commission recommendations. The Disability Program aims to ensure all children in care who are potentially eligible for NDIS funded services are identified and have access to appropriate diagnostic services to support referral to the NDIS where appropriate.

The Department for Child Protection has appointed a Director, Disability and Development and two Senior Disability Program Officers to lead the work to support children in care with disability including access to the NDIS.

A Memorandum of Understanding setting out a framework for delivering coordinated services to at risk children and young people was finalised in 2016. The MoU is targeted toward enhancing responses to children, young people and families who live in public housing or receive services from Housing SA; children and young people at risk of abuse or neglect; and children and young people under, or formerly under, guardianship of the minister.

## **WESTERN AUSTRALIA**

In July 2016, Western Australia launched the Building Safe and Strong Families: Earlier Intervention and Family Support Strategy (the Strategy). The Strategy provides a framework for the alignment of the service system to meet the current needs of families most vulnerable to their children entering OOHC. The Strategy focuses on four key areas:

- 1 Delivering shared outcomes through collective effort:**  
a system that is aligned and accountable to achieving shared outcomes for vulnerable families, with a focus on Aboriginal children and families.
- 2 A culturally competent service system:**  
a system that is safe and responsive to the needs of Aboriginal families.
- 3 Diverting families from the child protection system:**  
a system that identifies families that are vulnerable to involvement with the statutory child protection system and provides early and intensive support.
- 4 Preventing children entering out-of-home care:**  
a system that prioritises and aligns the Department's workforce and resources to prevent the most vulnerable children from entering out-of-home care.

Other reform projects relating to child protection services include:

- Building a Better Future: Out-of-Home Care reform in Western Australia - Outcomes Framework for children in OOHC in WA includes six outcome areas:
  - 1 Safe and stable** – children live safely in a stable care arrangement
  - 2 Healthy** – children have strong physical, social and mental health
  - 3 Achieve** – children attend, participate and achieve in quality education
  - 4 Belong** – children develop and retain a deep knowledge and understanding of their life-history and identity

- 5 **Included** – children are included by the systems that support them
  - 6 **Future life outcomes** – children leave care equipped with the resources to live productive lives.
- OOHC resource allocation framework; Recontracting of OOHC funded services; Leaving care policy - the Western Australian Government has also announced a trial to extend the leaving care age to 21, as part of the Home Stretch Campaign.





## APPENDIX C: Evidence based therapeutic OOHC systems and interventions

### **CLASSIFICATION OF THERAPEUTIC INTERVENTIONS FOR MALTREATED CHILDREN AND ADOLESCENTS**

The following is a classification of therapeutic interventions for maltreated children and adolescents from a 2016 review.<sup>57</sup> They should be used as indicated in an assessment of the individual needs and interests of the child or young person in out of home care, and as resources permit.

#### **Cognitive-behavioural therapies**

- Cognitive-behavioural therapy (CBT)
- Behavioural therapies
- Modelling and skills training
- Trauma-focused CBT (TF-CBT)
- Eye movement desensitization and reprocessing (EMDR).

#### **Relationship-based interventions (RBIs)**

- Attachment-orientated interventions
- Attachment and Biobehavioral Catch-up (ABC)
- Parent-child interaction therapy (PCIT)
- Parenting interventions
- Dyadic developmental psychotherapy (DDP).

#### **Systemic interventions**

- Systemic family therapy (FT)
- Transtheoretical intervention
- Multisystemic FT
- Multigroup FT
- Family-based programme.

#### **Psychoeducation**

#### **Group work with children**

#### **Psychotherapy (unspecified)**

#### **Counselling**

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<sup>57</sup> Macdonald G, Livingstone N, Hanratty J, et al. 'The effectiveness, acceptability and cost-effectiveness of psychosocial interventions for maltreated children and adolescents: an evidence synthesis.' Health Technology Assessment, No. 20.69. (UK): NIHR Journals Library; 2016 Sep.

## Peer mentoring

### Intensive service models

- Treatment foster care
- Therapeutic residential/day care
- Co-ordinated care.

### Activity-based therapies

- Arts therapy (art, music, theatre)
- Play/activity interventions (e.g. Wilderness Adventure Therapy; Farm therapy)
- Animal therapy (e.g. Equine therapy).

## **MODELS OF RESIDENTIAL CARE RATED BY THE CEBC**

The models of residential care considered below are evidence based therapeutic systemic or intensive service models that have a Scientific rating on the California Evidence Based Clearing House for Child Welfare (CEBC). The ratings are:

- 1** Well-Supported by Research Evidence
- 2** Supported by Research Evidence
- 3** Promising Research Evidence

Higher Levels of Placement in OOHC are defined by the CEBC as group, residential, and community treatment facilities with a rating classification level of 12 and above. (Note that there are approximately 15 rating classification levels of care for children in California, each of which represents more therapeutic and more restrictive care.) Child Welfare uses foster placement as a service to ensure the protection of children and youth who must be removed from the home of their parents or guardians because of the occurrence of abuse and neglect. Law and practice dictate that children be placed in the "least restrictive setting." The least restrictive placement for a child is in the home of their parent or guardian. The range of foster placements outside of the parents' or guardians' homes, from least to most restrictive, are the following: relative or non-related extended family member, foster family home, foster family agency home, group home, residential treatment centre, and community treatment facility.

The description of models below is taken from the CEBC web site.

## **TREATMENT FOSTER CARE OREGON – ADOLESCENTS (TFCO – A)**

*Previously known as Multidimensional Treatment Foster Care - Adolescents*

This is the highest rated model that is rated for 'higher levels of placement' (residential care) as well as specific behavioural or emotional problems.

**CEBC Rating** 1 – well supported in relation to Disruptive Behaviour Treatment (Child & Adolescent), Higher Levels of Placement (including Residential OOHC), Placement Stabilization Programs and Behavioural Management Programs for Adolescents in Child Welfare.;

**WHAT IT IS** Designed as an alternative to 'congregate'(residential/group) care. reduce the risk of incarceration of high-risk youth.

**Target Population** Boys and girls, 12-18 years old, with severe delinquency and/or severe emotional and behavioural disorders who were in need of out-of-home placement and could not be adequately served in lower levels of care.

Also provides treatment for the parents/carers of these young people.

- Specific behavioural problems: Hyperactivity, delinquency, school failure, history of abuse, depressive symptoms, aggression, anxiety, defiance, stealing, social aggression, and general anti-social behaviour

### **Goals**

- Eliminate or reduce youth problem behaviours
- Increase developmentally appropriate normative and prosocial behaviour in youth
- Transition youth to a birth family or lower level aftercare resource
- Improve youth peer associations
- Improve parent-child interaction and communication Improve youth coping and social skills
- Improve behaviour in school and provide academic support
- Increase parental skills, help them resolve conflict with children

## **THE MODEL OF THERAPEUTIC CHANGE**

Four key elements of treatment are (1) providing youths with a consistent reinforcing environment where they are mentored and encouraged to develop academic and positive living skills, (2) providing daily structure with clear they are expectations and limits, with well-specified consequences delivered in a teaching-oriented manner, (3) providing close supervision of youths' whereabouts, and (4) helping youth to avoid deviant peer associations while providing them with the support and assistance needed to establish pro-social peer relationships. TFCO also has versions for pre-schoolers and children.

### **Four key components**

- 1** Provides a consistent, reinforcing environment where the youth is mentored and encouraged to develop academic and positive living skills
- 2** Provides a daily structure with clear expectations and limits, with well-specified consequences delivered in a teaching-oriented manner
- 3** Provides close supervision of youths' whereabouts
- 4** Helps youth avoid deviant peer associations while providing support and assistance needed for youth to establish pro-social peer relationships

### **Other components**

- Allows only one treatment youth per home; may place sibling groups together depending on symptoms
- Provides clinical team with stratified roles, led by the Program Supervisor
- Has Program Supervisor with authority regarding the team & program
- Includes foster parents as members of the team
- Views the foster home as primary clinical environment
- Treats youth symptoms as skill deficits
- Uses daily contact with foster parent including collection of behavioural data on youth - Parent Daily Report
- Trains foster parents in TFCO-A prior to placement of a child
- Gives foster parents access to the Program Supervisor 24 hours a day/7 days a week

### **CHILD/ADOLESCENT SERVICES**

Treatment Foster Care Oregon - Adolescents (TFCO-A) directly provides services to children/adolescents and addresses the following:

- Hyperactivity
- Delinquency
- School failure
- History of abuse
- Depressive symptoms
- Aggression
- Anxiety
- Defiance
- Stealing
- Social aggression
- General anti-social behaviour

## **PARENT/CAREGIVER SERVICES**

Treatment Foster Care Oregon - Adolescents (TFCO-A) directly provides services to parents/caregivers and addresses the following:

- Lack of parenting skills
- Conflict issues with children

### **Services involving family/support structures**

This program involves the family or other support systems in the individual's treatment. TFCO-A highly involves the parents or long-term care resource in the treatment throughout services to learn new parenting skills.

## **RECOMMENDED PARAMETERS**

**Intensity** For foster parent(s), there is typically a minimum of seven contacts per week which consist of five 10-minute contacts, one two-hour group, and additional contacts based on the amount of support or consultation required. For the youth in treatment, two contacts per week which consist of a weekly individual therapy for one hour and weekly individual skills training in a two-hour session. For the biological family or other long-term placement resource, one contact per week in the form of a one-hour family therapy session.

**Duration** Designed with an overall treatment duration of 6-9 months.

### **Delivery settings**

This program is typically conducted in a(n):

- Birth Family Home
- Community Agency
- Foster/Kinship Care
- Outpatient Clinic
- School

### **Homework**

Treatment Foster Care Oregon - Adolescents (TFCO-A) includes a homework component:

Biological (or other long-term placement resource) parents are guided in practicing parenting skills outside of the sessions during visits with the child in foster care as well as with other children living in the home.

### **Languages**

Treatment Foster Care Oregon - Adolescents (TFCO-A) has materials available in languages other than English: Dutch, Swedish

## Resources

Office space for a team of approximately 6-8 people: Program Supervisor, Recruiter/Trainer/Parent Daily Report Caller, Family Therapist, Individual Therapist, and 2-3 Skills Trainers

Conference room with video recording

Internet access for Program Supervisor

## Minimum provider qualifications

- **Program supervisor** – In addition to a Master's degree in a clinical field and considerable relevant experience in behaviour management approaches, this person should possess supervisory skills, considerable organizational abilities, and a thorough understanding of and enthusiastic attitude toward the treatment model.
- **Family therapist** – Master's degree in a clinical field
- **Individual therapist** – Master's degree in a clinical field
- **Skills trainer(s)** – Bachelor's degree in a relevant field
- **Foster parent recruiter/trainer/PDR caller** – This important position should be filled by someone with a thorough understanding of the treatment model and experience in foster parent activities. The specific education level for this position is less important. This position can be filled by an experienced (ex-) foster parent.
- **Foster family** – No formal education is required for foster parents. However, foster parents trained in the program should have a basic understanding of child development with reasonable expectations for this population of foster children. It is especially helpful when foster parents have a good sense of humour and do not take behaviours personally.
- **Consulting psychiatrist** – Adequately serve children in the program who need medication prescribed and managed

## Education and training resources

There is a manual that describes how to implement this program, and there is training available for this program.

## Number of days/hours

5 days for a total of 40 hours

## Child welfare outcomes

 Permanency and Child/Family Well-Being

## References

- Chamberlain, P. (1994). *Family connections*. Eugene, OR: Northwest Media, Inc.
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- Chamberlain, P., & Mihalic, S. F. (1998). *Multidimensional treatment foster care: Blueprints for Violence Prevention, Book Eight*. Blueprints for Violence Prevention Series (D. S. Elliott, Series Editor). Boulder, CO: Center for the Study and Prevention of Violence, Institute of Behavioral Science, University of Colorado.

## **CARE: CHILDREN AND RESIDENTIAL EXPERIENCES (CARE)**

CARE is the only 'model' of residential OOHC that has a scientific rating (CEBC 3 – promising) AND has been specifically developed for use in that setting. The model describes the whole environment that must be created around the children in care in order to achieve the best outcomes for them. It does not specify specific therapeutic interventions – they will need to be brought in as indicated by professional assessment. It presupposes that the child's family will also be trained and supported to become part of the CARE environment.

**Scientific rating** 3 – (Promising research evidence)

**Higher level of placement** (12 out of 15 in terms of therapeutic orientation and restrictiveness).

**WHAT IT IS** '[an] intensive, principle-based program model designed to help organizations create more therapeutic care environments to enrich the day-to-day experiences of youth placed in out-of-home care. CARE is based on well-established scientific evidence about the developmental and relational needs of youth who experience trauma and other stressful experiences.'<sup>58</sup>

'CARE is a principle-based program designed to enhance the social dynamics in residential care settings through targeted staff development and ongoing reflective practice. Using an ecological approach, CARE aims to engage all staff at a residential care agency in a systematic effort to orient practices in order to provide developmentally enriched living environments and to create a sense of normality for youth. CARE is organized around six principles related to attachment, trauma recovery, and, ecological theory.'

The principles state that child care practices must be:

- Relationship-based;
- Trauma-informed;
- Developmentally focused;
- Competence-centred;
- Family-involved;
- Ecologically oriented'<sup>59</sup>

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<sup>58</sup> Holden J & Izzo C [The CARE Program Model: Theory to Quality Practice in Residential Child Care](#), Summary of presentation delivered on April 29, 2016 at the ALIGN conference in Edmonton, Alberta.

<sup>59</sup> [CEBC CARE](#)



## **RECOMMENDED PARAMETERS**

### **Delivery settings**

This program is typically conducted in a(n):

- Foster/Kinship Care;
- Residential Care Facility;
- School

### **Languages**

Children and Residential Experiences (CARE) does not have materials available in a language other than English.

### **Targeting**

Child-care staff, clinical staff, and agency administrators working with 6- to 20-year-old children and youth living in residential care settings

### **Training**

‘CARE consultants follow a standardized set of steps to train and support staff over the 3-year implementation period. An essential activity is the formation of a local Implementation Team with multilevel representation that provides support, modelling, and mentoring to staff as they incorporate CARE principles into their work. This approach is designed to cultivate personal investment and ownership among all staff levels at the agency.’<sup>60</sup>

### **Program goals**

- Improve relationship quality between staff and children/adolescents;
- Increase the use of trauma-informed practices by staff;
- Improve social and emotional functioning among the children and adolescents;
- Reduce the number of high-risk behavioural incidents such as aggression, property destruction, and running away;
- Reduce the use of physical restraints and other restrictive practices;
- Improve academic achievement and overall functioning in school or vocational settings among children and adolescents;
- Increase contacts between children and their families while in care;
- Increase agency’s capacity to collect, analyze, and use data in decision-making;
- Reduce staff turnover.

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<sup>60</sup> Ibid.

## ESSENTIAL COMPONENTS

The essential components of the Children and Residential Experiences (CARE) model include:

### A practice model based on 6 core principles

- 1 Relationship-based:** Form healthy models of adult-child relationships and build capacity for future relationships;
- 2 Trauma-informed:** Use professional practice that is sensitive to youth's trauma history;
- 3 Developmentally focused:** Provide normative developmental experiences and adapt expectations to meet individual needs;
- 4 Competence-centred:** Foster self-efficacy and competence for dealing with life circumstances;
- 5 Family-involved:** Understand and adapt to families' cultural norms and promote active family involvement;
- 6 Ecologically oriented:** Enrich the physical and social environment to create a therapeutic milieu.

### Embedding in organisational culture

Committed leadership and an implementation team that guide and facilitate agency-wide training and technical assistance to help personnel at all levels of the facility learn to use the 6 principles to enhance interactions with children by focusing on strengthening attachments, building competencies, adjusting expectations to account for children's developmental stage and trauma history, involving families in the child's care and treatment, and enriching dimensions of the environment to create a more therapeutic milieu.

On-going agency-wide incorporation of the 6 principles in leadership, policies and procedures, training and professional development of staff, supervision, and all interactions with children and families.

Consistent application of the 6 principles within and across all levels of the agency, including administration, supervision, clinical care, education, and direct care.

### Recommended duration

Implementation of the program typically requires 3 years. Once implemented, the program continues indefinitely as a framework that guides the treatment philosophy of the organization as it provides out-of-home care and treatment to its clients.

### **Minimum provider qualifications**

There are no educational requirements to become a trainer of trainers. Anyone interested in becoming one must attend a training of trainer's course and pass the written test to be certified.

### **Education and training resources**

There is a manual that describes how to implement this program, and there is training available for this program.

### **Training**

Onsite training is provided as part of an implementation agreement and contract with Cornell University. During the implementation period, Cornell consultants collaborate with agency leadership to assist the agency in fully implementing the CARE model. Consultation includes leadership retreats during which agency leaders are trained in the CARE model and principles. In addition, Cornell consultants conduct a 5-day train-the-trainer event during which CARE Educators are prepared to train other agency staff in the CARE model.

### **Number of days/hours**

Leadership and Implementation Team members are trained in the CARE principles and develop an agency-specific implementation plan through a 4-day manualized program. CARE educators are trained in CARE principles and training methods through a 5-day manualized program. Agency staff are trained in CARE principles through a 5-day training program. CARE educators must be recertified regularly.

### **References**

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## WRAPAROUND

**CEBC scientific rating** 3 – promising as a placement stabilisation program

**WHAT IT IS** A team-based planning process intended to provide individualized and coordinated family-driven care that will meet the complex needs of children who are involved with several child and family-serving systems (e.g., mental health, child welfare, juvenile justice, special education, etc.), who are at risk of placement in institutional settings, and who experience emotional, behavioural, or mental health difficulties.

The process requires that families, providers, and key members of the family's social support network collaborate to build a creative plan that responds to the particular needs of the child and family. Team members then implement the plan and continue to meet regularly to monitor progress and make adjustments to the plan as necessary. The team continues its work until members reach a consensus that a formal process is no longer needed.

**Delivery setting** Home-based primarily, but could be used for residential OOHC

## ESSENTIAL COMPONENTS

### 10 Principles

- 1 Family voice and choice** Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.
- 2 Team based** The wraparound team consists of individuals agreed upon by the family and committed to the family through informal, formal, and community support and service relationships.
- 3 Natural supports** The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.
- 4 Collaboration** Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.

- 5 Community based** The wraparound team implements service and support strategies that take place in the most inclusive, responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.
- 6 Culturally competent** The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/ youth and family, and their community.
- 7 Individualized** To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.
- 8 Strengths based** The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.
- 9 Unconditional** A wraparound team does not give up on, blame, or reject children, youth, and their families. When faced with challenges or setbacks, the team continues working towards meeting the needs of the youth and family and towards achieving the goals in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer necessary.
- 10 Outcome based** The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

## **PRACTICE AS FOLLOWS**

### **PHASE 1: Engagement and team preparation**

- Orient the family and youth to wraparound and address legal and ethical issues
- Stabilize crises: Elicit information from family members, agency representatives and potential team members about immediate crises or potential crises, and prepare a response
- Explore strengths, needs, culture, and vision during conversations with child/youth and family, and prepare summary document
- Engage and orient other team members
- Make necessary meeting arrangements

### **PHASE 2: Initial plan development**

- Develop an initial plan of care: Determine ground rules, describe and document strengths, create team mission, describe and prioritize needs/goals, determine outcomes and indicators for each goal, select strategies, and assign action steps

- Create a safety/crisis plan to ameliorate risk and respond to potential emergencies
- Complete necessary documentation and logistics

### **PHASE 3: Implementation**

- Implement action steps for each strategy of the wraparound plan, track progress on action steps, evaluate success of strategies, and celebrate successes
- Revisit and update the plan, considering new strategies as necessary
- Maintain/build team cohesiveness and trust by maintaining awareness of team members' satisfaction and "buy-in," and addressing disagreements or conflict
- Complete necessary documentation and logistics

### **PHASE 4: Transition**

- Plan for cessation of formal wraparound: Create a transition plan and a post-transition crisis management plan, and modify the wraparound process to reflect transition
- Create a "commencement" by documenting the team's work and celebrating success
- Follow up with the family

## **CHILD/ADOLESCENT SERVICES**

*Wraparound* directly provides services to children/adolescents and addresses the following:

- Severe emotional
- Behavioural, or mental health difficulties
- Their families where the young people are often in, or at risk for, out of home, institutional, or restrictive placements, and are involved in multiple child and family-serving systems (e.g., child welfare, mental health, juvenile justice, special education, etc.)

## **PARENT/CAREGIVER SERVICES**

*Wraparound* directly provides services to parents/caregivers and addresses the following:

- Child in foster or residential care
- Child in child welfare system
- Child in juvenile justice system
- Child with significant emotional and behavioural problems
- Child at-risk for out-of-home placement

## RECOMMENDED PARAMETERS

### Recommended intensity

This can vary. Usually there is an intensive engagement and initial planning process that may require two 60-90-minute sessions with the family and two team sessions during the first three weeks to a month. The team continues to meet thereafter, usually with increased intensity in the early phases (often once per month or even more) and decreasing thereafter. The care coordinator, facilitator, and parent partner could have other contacts with the youth and family as necessary. Services and supports called for in the plan are provided by other team members or by people not included on the team.

### Recommended duration

Well-established programs provide services for an average of 14 months or so

### Delivery settings

This program is typically conducted in a(n):

- Adoptive Home
- Birth Family Home
- Community Agency
- Foster/Kinship Care
- Residential Care Facility

### Program goals

The goals of *Wraparound* are:

- Maintain children with highest levels of mental health and related needs successfully and safely in their homes and communities
- Improve functioning across life domains
- Decrease out-of-home placements

**Target population** Designed for children and youth with severe emotional, behavioural, or mental health difficulties and their families where the child/youth is in, or at risk for, out-of-home, institutional, or restrictive placements, and involved in multiple child and family-serving systems (e.g., child welfare, mental health, juvenile justice, special education, etc.)

**For children/adolescents ages** 0 – 17

**For parents/caregivers of children ages** 0 – 17



## REQUIRED RESOURCES

The typical resources for implementing the program are:

Most of the cost is in personnel. Programs typically hire care coordinators with caseloads of 10-15 families. Additionally, most programs hire parent advocates/parent partners to work with teams. Because this program is typically a collaborative effort, implementation usually (but not always) requires some sort of interagency oversight or governance body with representation from participating child- and family-serving agencies and organizations.

### Minimum qualifications for providers

Most programs require staff to be at least at the Bachelor's level for care coordinator and supervisory positions. Requirements for family partners are flexible. The most important qualification is expertise in multiagency collaboration and the program itself.

### Education and training

There *is* a manual that describes how to implement this program, and there *is* training available.

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## **SANCTUARY (BLOOM)<sup>61</sup>**

**CEBC scientific rating** 3 – promising for Higher Levels of Placement (e.g. residential OOHC) and Trauma Treatment - System-Level Programs (Child & Adolescent).

**WHAT IT IS** A system for creating a pervasive trauma- informed culture in organizations to improve care quality and outcomes for clients who have experienced trauma. It is a model that applies to a system, not individual care.

### **Target population**

This program is not a client-specific intervention, but a full-system approach that targets the entire organization with the intention of improving client care and outcomes. The focus is to create a trauma-informed and trauma-sensitive environment in which specific trauma-focused interventions can be effectively implemented.

**For children/adolescents ages** 12 – 20

**For parents/caregivers of children ages** 12 – 20

The *Sanctuary Model*<sup>®</sup> is a blueprint for clinical and organizational change which, at its core, promotes safety and recovery from adversity through the active creation of a trauma-informed community. A recognition that trauma is pervasive in the experience of human beings forms the basis for the Sanctuary Model's focus not only on the people who seek services, but equally on the people and systems who provide those services. Sanctuary has been used in organizations that provide residential treatment for youth, juvenile justice programs, homeless and domestic violence shelters as well as a range of community-based, school-based and mental health programs.

## **PROGRAM GOALS**

The goals of the *Sanctuary Model*<sup>®</sup> are:

- Create a collaborative treatment environment
- Work more effectively and therapeutically with traumatized clients
- Improve treatment outcomes as determined by individual agency service goals
- Reduce restraints and other coercive practices
- Build high-functioning multidisciplinary teams
- Improve staff morale
- Increase measurable levels of hope, safety, trust, emotional intelligence and problem-solving skills in both staff and clients
- Increase employee retention

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<sup>61</sup> Bloom, S. L. (2005) Introduction to Special Section- [Creating Sanctuary for Kids: Helping Children to Heal From Violence](#). Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations 26(1): 57-63.

- Support the mission and services of the organization by adding a trauma lens

## ESSENTIAL COMPONENTS

The essential components of the *Sanctuary Model*<sup>®</sup> include:

### The following four pillars

- 1** A theoretical basis in trauma theory that provides a lens for understanding behaviour and the impact of trauma on individuals as well as organizations and systems
  - 2** A philosophy for creating safe environments through community adherence to Seven Commitments, each targeted to mitigate the effects of trauma for all those who work or receive services in the organizational community:
    - Nonviolence;
    - Emotional intelligence;
    - Social learning;
    - Democracy;
    - Open communication;
    - Social responsibility;
    - Growth & change
  - 3** The trauma-informed problem-solving framework represented by the acronym S.E.L.F., which stands for Safety, Emotions, Loss, and Future; four categories which represent major areas of disruption caused by trauma exposure and target areas for planning and measuring recovery
  - 4** A set of practical tools, known as the *Sanctuary Tool Kit* which includes individual and community practices to build emotion regulation skills of individuals and build protective factors into the community
- Three Sanctuary Psychoeducation curricula for youth (Learning through Film; Learning from our Leaders and S.E.L.F. Psychoeducation) are offered as part of the implementation process or can be delivered as stand-alone groups
  - Sanctuary Psychoeducation curricula for parents/caregivers (Teaching Families about Sanctuary and the Sanctuary Multi-Family Group Curriculum) are offered as part of the implementation process or can be delivered as stand-alone trauma focused groups

## **CHILD/ADOLESCENT SERVICES**

**Sanctuary Model** directly provides services to children/adolescents and addresses the following:

- Problems and symptoms addressed are those generally associated with a diagnosis of posttraumatic stress disorder (PTSD) or exposure to trauma, chronic stress and adversity, specifically in the areas of:
- Safety (including physical, social, psychological, and moral)
- Emotion recognition and management
- Unresolved loss or complex grief
- Foreshortened sense of future or feelings of powerlessness to create one's future

## **PARENT/CAREGIVER SERVICES**

**Sanctuary Model** directly provides services to parents/caregivers and addresses the following:

- Physical, psychological, social and moral safety in the home environment
- Certain childhood behaviours as manifestations of trauma exposure
- Trauma symptoms that manifest in disruptive behaviours
- Attachment and relationships between parents and children
- Traumatic re-enactment in the home environment
- Emotion recognition and management skills for parents and children
- Loss and grief related to trauma in a family

## **RECOMMENDED PARAMETERS**

**Intensity** This is an organizational model that shapes the treatment milieu, offers some clinical tools and is used continually once it is implemented. See Training and Implementation sections below for more information.

**Duration** Once implemented, clients receive Sanctuary model throughout their residence in the program See Training and Implementation sections below for more information.

### **Delivery settings**

This program is typically conducted in a(n):

- Community Agency
- Department of Social Services
- Homeless Shelter
- Outpatient Clinic
- Residential Treatment Center
- School
- Domestic Violence Shelter

Sanctuary implementation is typically a three-year process:

### **Year 1 – Engaging**

- This year centres on training and inviting members of the organization to participate and test their comfort with the concepts of Sanctuary.
- The areas of focus are the most concrete components of the model - the language and organizing structure of S.E.L.F. and the Sanctuary Toolkit.
- The primary vehicles for engaging are training and planning through Core Team meetings with the beginnings of practice in using the tools and some evaluation of that process.

### **Year 2 – Embedding**

- This year centres on adapting policies and practices to align with Sanctuary as the work that leads to intensive culture change.
- The areas of focus are the more philosophical and potentially more abstract concepts – operationalizing the seven Sanctuary Commitments and S.E.L.F while honing a trauma informed environment by paying attention to culture and sharpening trauma treatment skills.
- The primary vehicles for embedding are planning and practice with less emphasis on training and some increased use of evaluation at the end of the second year.

### **Year 3 – Evaluating**

- This year centres on measuring the organization’s progress against the Sanctuary Implementation Standards.
- The focus is on revisiting the Implementation tasks, particularly the tools, to redirect any areas of drift.
- The primary vehicles are planning through Core Team and subgroup work as well as formal and informal evaluation of fidelity and sustainability.

### **Number of days/hours**

The initial training for a select group of employees lasts 5 days and is followed by a three-year agency consultation period.

All staff members participate in a minimum of 15 hours of in-house training per year to maintain knowledge and skills for practice of the Model.

### **References**

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## **MULTISYSTEMIC THERAPY FOR CHILD ABUSE AND NEGLECT (MST-CAN)**

**CEBC rating** 2 – promising in relation to Interventions for abusive behaviour

**WHAT IT IS** Multi-systemic – i.e. designed to address multiple determinants of maltreatment.

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN) is an adaptation of Multisystemic Therapy (MST) that has been specifically designed to treat youth ages 6 to 17 and their families who have come to the attention of child protection due to physical abuse and/or neglect.

**Delivery settings** Home based or other convenient location

**Target population** Families who have come to the attention of Child Protective Services within the past 180 days due to the physical abuse and/or neglect of a child in the family between the ages of 6 and 17; where the child is still living with them or is in foster care with the intent of reunifying with the parent(s); other criteria may apply

### **DESCRIPTION**

MST-CAN is for families with serious clinical needs who have come to the attention of child protective services (CPS) due to physical abuse and/or neglect. MST-CAN clinicians work on a team of 3 therapists, a crisis caseworker, a part-time psychiatrist who can treat children and adults, and a full-time supervisor. Each therapist carries a maximum caseload of 4 families. Treatment is provided to all adults and children in the family. Services are provided in the family's home or other convenient places. Extensive safety protocols are geared towards preventing re-abuse and placement of children and the team works to foster a close working relationship between CPS and the family. Empirically-based treatments are used when needed and include functional analysis of the use of force, family communication and problem solving, Cognitive Behavioural Therapy for anger management and posttraumatic stress disorder (PTSD), clarification of the abuse or neglect, and Reinforcement Based Therapy for adult substance abuse.

### **PROGRAM GOALS**

The goals of Multisystemic Therapy for Child Abuse and Neglect (MST-CAN) are:

- Reduce abuse or neglect
- Reduce out-of-home placement
- Improve parenting (without violence, psychological aggression, or neglect)
- Improve parent mental health functioning
- Improve youth mental health functioning
- Increase social support

## ESSENTIAL COMPONENTS

The essential components of *Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)* include:

- Clients:
  - Youth between the ages of 6 and 17
  - Youth who have come to the attention of child protective services due to physical abuse and/or neglect and for whom the abuse report was filed within the last 180 days
  - Youth who are currently in foster care or another out-of-home placement and will be reuniting with their family
- Intervention Context:
  - Services provided in the family's home or other places convenient to them and at times convenient to the family
  - Intensive services, with intervention sessions being conducted from three times per week to daily
  - 24/7 on-call roster utilized to provide round-the-clock services for families
  - Treatment provided to multiple children in the family and one or both parents, with a greater emphasis on parent treatment than standard [MST](#)
- Therapists and Supervisors:
  - **MST-CAN** staff work on a clinical team of 3 therapists, a crisis caseworker, a part-time psychiatrist, and a full-time supervisor
  - **MST-CAN** supervisor must have the following criteria:
    - An understanding of the child protective services system
    - Experience with family therapy and cognitive behavioural therapy for posttraumatic stress disorder (PTSD)/trauma
    - Experience in managing severe family crises that involve safety risk to the children or entire family
    - A thorough understanding of state mandated abuse reporting laws
    - A PhD or Master's degree in counselling, social work, or a related field
  - Supervisors must be full-time and may supervise a single team only
  - The **MST-CAN** therapist must have a Master's degree in counselling, social work, or a related field
  - The **MST-CAN** Team must have access to an appropriate percentage of an adult and child psychiatrist's time that has been trained in the MST and **MST-CAN** treatment models and is integrated into the clinical team
  - The **MST-CAN** team must include one full-time crisis caseworker with a Bachelor's degree



- Application of the Intervention:
  - Interventions developed along an analytical model that guides the therapist to assess factors that are driving clinical problems and then applied to the driving factors or “fit factors”
  - All interventions evidence-based or evidence-informed
  - Each therapist carries a maximum caseload of 4 families and case length is 6-9 months
- Program Fidelity and Quality Assurance:
  - Each team member completes a 5-day MST orientation training, a 4-day **MST-CAN** training, and 4 days of training in adult and child trauma treatment
  - Weekly on-site group supervision
  - Weekly telephone consultation with an **MST-CAN** expert
  - Quarterly on-site booster trainings conducted by the **MST-CAN** expert
  - Measurement of model adherence through monthly phone interviews with the parent or caregiver.
- Program Monitoring and Use of Data:
  - Agencies collect data as specified by MST Services and all data are sent to the MST Institute (MSTI) which is charged with keeping the national database system.
  - MSTI data reports used to assess and guide program implementation
  - Agencies use these reports to monitor and assure fidelity to the MST model
  - There must be a formal Memorandum of Agreement (MOA) in place regarding access to abuse and placement data prior to implementation

## **CHILD/ADOLESCENT SERVICES**

***Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)*** directly provides services to children/adolescents and addresses the following:

- Physical abuse and/or neglect for which the report to child protective services was filed within the last 180 days
- Youth aggression
- Anxiety and trauma/PTSD
- Substance abuse
- Difficulty managing anger
- Safety risks
- Difficulties with family problem solving
- Negative family communication
- Physical force in parenting
- Neglectful parenting

- Parental psychological aggression
- Low social support
- Parental blame of the child for the abuse/neglect
- School difficulties

## **PARENT/CAREGIVER SERVICES**

*Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)* directly provides services to parents/caregivers and addresses the following:

- Has a child who experienced physical abuse and/or neglect for which the report to CPS was filed within the last 180 days
- Anxiety and trauma/PTSD
- Depression
- Substance abuse
- Difficulty managing anger
- Safety risks
- Difficulties with family problem solving
- Negative family communication
- Physical force in parenting
- Neglectful parenting
- Parental psychological aggression
- Low social support
- Parental blame of the child for the abuse/neglect
- Difficulties maintaining housing or jobs

### **Services involving family/support structures**

This program involves the family or other support systems in the individual's treatment: Direct treatment services provided to family. Collaboration with other supportive individuals, including them as part of the treatment team.

## **RECOMMENDED PARAMETERS**

**Intensity** Services are intensive, with intervention sessions being conducted from three times per week to daily. However, there is no expectation of a specific number of contact hours, as staff contact waxes and wanes according to the needs of the families. Session length depends on the needs of the family and may range from 50 minutes to 2 hours. Multiple types of sessions may be conducted in one day (e.g., parental drug screening and session; family communication and problem solving).

**Duration** 6-9 months

### **Delivery settings**

This program is typically conducted in a(n):

- Adoptive Home
- Birth Family Home
- Foster/Kinship Care
- School

## Homework

**Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)** includes a homework component: Homework may be assigned in relation to any of the following interventions:

- Parent Management Training
- Treatment of caregiver posttraumatic stress disorder (PTSD)
- Treatment for anger management
- Treatment for caregiver substance abuse
- Family communication training

**Languages** **Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)** has materials available in languages other than English: Dutch, Norwegian, Swiss German

**Resources** Typically office space to house the team and conduct consultation and supervision is required as well as laptops and mobile phones for all staff.

## Minimum provider qualifications

**MST-CAN** Supervisor:

- Must be assigned to **MST-CAN** 100%.
- Must have a Master's degree in counselling, social work, or a related field
- Must be independently licensed.
- May only supervise a single team
- May not carry their own caseload
- Must have an understanding of the child welfare system
- Must have experience in managing severe family crises that involve safety risk to the children and/or entire family
- Must have a thorough understanding of state and national mandated abuse reporting laws
- Should have experience implementing Standard MST or **MST-CAN**
- Should have knowledge and experience in the **MST-CAN** Supervision Model
- Should have experience with family therapy and Cognitive-Behavioural Therapy (CBT) for Post-traumatic Stress Disorder (PTSD)

**MST-CAN** Therapist:

- Must be assigned to a single **MST-CAN** team 100%
- Must have a Master's degree in counseling, social work, or a related field
- Should have a background in child development
- Should have an understanding of family violence
- Should have skills in engaging families reluctant to participate
- Should have experience in crisis intervention where homicidal or suicidal risk is present
- Should have knowledge of the child welfare system.

**MST-CAN** Crisis Caseworker:

- Must be assigned to a single MST-CAN team 100%
- Must have a minimum of a Bachelor's degree
- Should have knowledge, of interventions related to practical life skills such as employment seeking, budgeting, and housing
- Should have experience in the child welfare system
- Should have knowledge of child development

**MST-CAN** Psychiatrist:

- Must be available to team at least 8 hours per week
- MD or DO, board certification eligibility in Child and Adolescent Psychiatry
- Must be trained in the MST treatment model and the MST-CAN adaptations by MST, Inc.
- Must have a thorough understanding of state and national mandated abuse reporting laws
- Should have a thorough understanding of existing ethical guidelines and laws concerning clinical situations that may occur in crisis treatment (i.e., restraints, commitments, reporting abuse or neglect)
- Should have experience with both child and adult populations
- Should have experience in trauma treatment for youth and adults
- Should have experience working in local organizations and systems

**Education and training resources**

There is a manual that describes how to implement this program, and there is training available for this program.

**Duration**

MST-CAN is an intensive therapy, lasting six to nine months that addresses the specific problems that brought the family to child protective services plus important risk factors. The major goals of MST-CAN are to keep families together, assure that

children are safe, prevent abuse and neglect, reduce mental health difficulties experienced by adults and children, and increase natural social supports.

### **Quality assurance and fidelity measures**

*Multisystemic Therapy for Child Abuse and Neglect (MST-CAN®)* is one of two therapeutic interventions to be used under Their Futures Matter policy (in addition to Functional Family Therapy for Child Welfare (FFT-CW®)) as well as TFCO.

Developed for residential care? NO, but has been adapted

*MST-CAN* is evidence-based (randomized clinical trials)

*MST-CAN* is delivered in home and community settings

*MST-CAN* addresses the multiple determinants of maltreatment

*MST-CAN* provides an individualized safety plan for each family

*MST-CAN* provides professional training and support

### **Target group**

Children and adolescents – particularly juvenile offenders

### **Conceptual basis**

**Social ecological theory** Antisocial behaviour in youth is conceptualised as being influenced by many interplaying areas in the young person's life including family, friends, school and the young person's community.

### **MODEL OF CHANGE**

Adverse influences in the client's environment need to be identified and replaced with positive influences.

MST is a home and community-based team intervention with therapists working in teams of two to four with a supervisor and access to a consultant. Therapists have small case-loads (four to six families) and teams are required to be on call 24 hours a day 7 days a week and do 'whatever it takes' to achieve the desired outcomes of decreased antisocial behaviour in the youth. Intervention is brief (3 to 5 months) but intensive (60+ hours of direct therapist contact). Interventions are present focused, strengths-based and solution-orientated, using a problem-solving approach to guide the development of interventions. MST draws on many interventions, including CBT, motivational interviewing, systemic, structural and strategic family therapy and behavioural interventions such as token economies. Strategies such as drug and alcohol screening are also used to ensure compliance with interventions.

The book provides a well-structured intervention process based on the nine principles outlined above. Each chapter addresses a system in the youth's life and provides an excellent practical and well-researched guide to developing and implementing interventions with numerous case examples to illustrate interventions in real life situations. The chapter on family is extensive as family/caregivers are considered crucial to the change and influence of other systems in the youth's life — for example, peers. Engagement of caregivers is of utmost importance in developing and implementing interventions for change and sustaining those interventions over time. Therapeutic alliance with caregivers is considered crucial to good outcomes. Barriers to engagement and implementation of strategies such as parenting style, caregiver anxiety or depression are discussed in detail in this and other chapters, with practical interventions and examples to overcome these issues.

Chapters on peer interventions and promoting educational and or vocational success continue with the positive and strength-based interventions to address these important systems within the youth's life. Helping the young person to develop friendships outside of a deviant peer group is seen as a priority, as is ensuring the youth remains within an educational environment, preferably school. A chapter on individual interventions is located after interventions in other systems and addresses

issues such as youth ADHD and PTSD and carer anxiety and depression. The chapter on building social supports for families assesses current and required resources that caregivers need to maintain — for example, work and after-school supervision of youth — by using a problem-solving approach to identify and recruit people to help, as well as educate caregivers on how to reciprocate support within their means. Substance abuse is addressed in a chapter that discusses the use of Contingency Management (CM) interventions to complement the MST model for treatment of this issue.

The final two chapters of the book give the reader a comprehensive knowledge of the research that proves the effectiveness of MST in outcomes with antisocial behaviour in young people, as well as in some other areas such as chronic illness (diabetes). The quality assurance and quality improvement of MST provides a detailed structure on how organisations can adopt this intervention, and the requirements of organisations, therapists, supervisors and clinical experts to ensure good outcomes for MST interventions.

**MST has nine principles that underpin intervention:**

- 1** Finding the fit — the fit between the young persons presenting problem and their broader systemic context.
- 2** Positive and strengths focused — all therapeutic contact is positive and uses strengths to promote change.
- 3** Increasing responsibility — interventions promote responsible behaviour and decrease irresponsible behaviour.
- 4** Present-focused, action-orientated and well-defined interventions are based on the here and now and are goal-defined and driven.
- 5** Targeting sequences — interventions are designed to target sequences of behaviour in multiple systems for example family, peers and school.
- 6** Developmentally appropriate — interventions are designed to be appropriate for the young person's age and developmental life stage.
- 7** Continuous effort — interventions are designed to require the youth and family to have constant effort in achieving change.
- 8** Evaluation and accountability — continuous evaluation of the youth's presenting problems, identifying barriers to change and the therapist is accountable for overcoming these barriers.
- 9** Generalisation — interventions are targeted to be sustainable by providing caregivers with the ability and resources to address the family's needs across systems.

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## **FUNCTIONAL FAMILY THERAPY – CHILD WELFARE (FFT-CW)**

**CEBC rating** 2 – rated by California Evidence Based Clearing House for Child Welfare – one of three programs to be used by NSW FACS

**WHAT IT IS** *FFT* is a family intervention program for dysfunctional youth. *FFT* has been applied to a wide range of problem youth and their families in various multi-ethnic, multicultural contexts.

**Targets** Youth aged 11-18, but younger siblings of referred adolescents often become part of the intervention process. Target populations range from at-risk pre-adolescents to youth with very serious problems such as conduct disorder, violent acting-out, and substance abuse.

**Intervention** Ranges from, on average, 8 to 12 one-hour sessions for mild cases and up to 30 sessions of direct service for more difficult situations. In most programs, sessions are spread over a three-month period. *FFT* has been conducted both in clinic settings as an outpatient therapy and as a home-based model.

### **PROGRAM GOALS**

The goals of Functional Family Therapy (FFT) are:

- Engage and motivate youth and their families by decreasing the intense negativity (blaming, hopelessness) so often characteristic of these families. Rather than ignoring or being paralyzed by the intense negative experiences these families often bring (e.g., cultural isolation and racism, loss and deprivation, abandonment, abuse, depression), FFT acknowledges and incorporates these powerful emotional forces into successful engagement and motivation through respect, sensitivity, and positive reattribution techniques.
- Reduce and eliminate the problem behaviours (e.g., conduct disorder, violent acting-out, and substance abuse) and accompanying family relational patterns through individualized behaviour change interventions. During this phase, FFT integrates a strong cognitive/attributional component into systematic skill- training in family communication, parenting, problem solving, and conflict management skills.
- Generalize changes across problem situations by increasing the family's capacity to utilize multisystemic community resources adequately, and to engage in relapse prevention.
- **Inherent in these phases.** They target deficiencies/ dysfunction in relationships, skills and understanding.

## MODEL OF THERAPEUTIC CHANGE

FFT is applied in five distinct phases: engagement, motivation, relational assessment, behaviour change, and generalization. In the Engagement Phase, the focus is on maximizing family members' initial expectations/perceptions about treatment to facilitate their attendance at the first treatment session.

Each phase has its own unique goals, risk and protective factors addressed, assessment focus, and therapist skills and intervention focus.

- **Engagement**
  - **Goal:** Maximize family initial expectation of positive change
  - **Risk and protective factors addressed:**
    - Negative perception about or experiences with treatment
    - Reputation of treatment agency
    - Transportation
    - Therapist availability
    - Intake staff skills and attitudes
  - **Assessment focus:** Superficial qualities inferred from referral source and initial screening
  - **Therapist skills/intervention focus:**
    - High availability
    - Manage intake processes to present agency, self, and treatment in a way that matches to inferred family characteristics
    - Enhance perception of credibility
- **Motivation**
  - **Goal:** Create a motivational context for long-term change
  - **Risk and protective factors addressed:**
    - Family negativity and blame
    - Hopelessness
    - Level of motivation
  - **Assessment focus:**
    - Behavioural (presenting problem)
    - Relational risk and protective factors
  - **Therapist skills/intervention focus:**
    - Interpersonal skills (validation, positive reattribution, reframing, relational)
    - Build balanced alliances
    - Reduce negativity and blame
    - Create hope
    - Enhance motivation to change
- **Behaviour Change**
  - **Goal:** Facilitate individual and interactive/ relational change

- **Risk and protective factors addressed:**
  - Youth temperament
  - Parental pathology
  - Beliefs and values
  - Developmental level
  - Parenting skills
  - Conflict resolution/negotiation skills
  - Level of family support
  - Peer refusal skills
- **Assessment focus:**
  - Individual skills
  - Quality of relational skills
  - Relational problem sequence
  - Compliance with behaviour change plans
- **Therapist skills/intervention focus:**
  - Directive/teaching /structuring skills
  - Modelling
  - Setting up, leading, and reviewing in-session tasks
  - Assigning homework
- **Generalization**
  - **Goal:** Maintain individual and family change, and facilitate change in multiple systems
  - **Risk and protective factors addressed:**
    - Youth bonding to school
    - Parent attitudes about school, peers, drugs, etc.
    - Level of social support
  - **Assessment focus:**
    - Access to and utilization of community resources
    - Maintenance of change
  - **Therapist skills/intervention focus:**
    - Interpersonal and structuring skills
    - Family case manager
    - Accessing appropriate formal and informal community resources
    - Anticipate and plan for future extra-familial stresses

In the *Motivation* phase, the focus is on reducing family conflict, blame, and hopelessness and developing a relational focus and balanced alliances with family members to create a motivational context for change. In the *Relational Assessment* phase, the focus is on identifying the interactional and functional aspects of specific behaviours, attributions, and feelings of family members and extra-familial significant others (e.g., close relatives, peers). This assessment sets the stage for designing and implementing the *Behaviour Change* phase, which involves training and applying

maintenance technology (e.g., parent-child communication training, behavioural contracting, emotional expression and regulation). Skills training interventions such as problem-solving and other behavioural intervention strategies are included using a menu-driven process from the behaviour therapy literature (e.g., listening skills, anger management, parent-directed behavioural consequences, improved parental supervision). A unique feature of FFT is the specific focus on skills in the context of assessed relational functions of behaviour (e.g., separation, contact) within each dyad of the family system. The focus of change is on replacing maladaptive behaviours used to maintain relationship functions. In the *Generalization* phase, the focus is on extending new skills and behaviours to the home and environment to maintain and extend the treatment gains independently from the therapist.

## Reference

- Robbins, M. S., Alexander, J. F., Turner, C. W., & Hollimon, A. (2016). *Evolution of functional family therapy as an evidence-based practice for adolescents with disruptive behavior problems*. *Family Process*, 55(3), 543–557. <https://doi.org/10.1111/famp.12230>



## **APPENDIX D: RECOMMENDATIONS FROM THE ROYAL COMMISSION INTO INSTITUTIONAL RESPONSES TO CHILD SEXUAL ABUSE**

Final report recommendations from the Royal Commission into Institutional Responses to Child Sexual Abuse, including volumes six, 10 and 12.

### **VOLUME 6 – MAKING INSTITUTIONS CHILD SAFE RECOMMENDATIONS**

#### **CREATING CHILD SAFE COMMUNITIES THROUGH PREVENTION**

##### **Recommendation 6.1**

The Australian Government should establish a mechanism to oversee the development and implementation of a national strategy to prevent child sexual abuse. This work should be undertaken by the proposed National Office for Child Safety (see Recommendations 6.16 and 6.17) and be included in the National Framework for Child Safety (see Recommendation 6.15).

##### **Recommendation 6.2**

The national strategy to prevent child sexual abuse should encompass the following complementary initiatives:

- Social marketing campaigns to raise general community awareness and increase knowledge of child sexual abuse, to change problematic attitudes and behaviour relating to such abuse, and to promote and direct people to related prevention initiatives, information and help-seeking services
- Prevention education delivered through preschool, school and other community institutional settings that aims to increase children's knowledge of child sexual abuse and build practical skills to assist in strengthening self-protective skills and strategies. The education should be integrated into existing school curricula and link with related areas such as respectful relationships education and sexuality education. It should be mandatory for all preschools and schools
- Prevention education for parents delivered through day care, preschool, school, sport and recreational settings, and other institutional and community settings. The education should aim to increase knowledge of child sexual abuse and its impacts, and build skills to help reduce the risks of child sexual abuse
- Online safety education for children, delivered via schools. Ministers for education, through the Council of Australian Governments, should establish a nationally consistent curriculum for online safety education in schools. The Office of the

eSafety Commissioner should be consulted on the design of the curriculum and contribute to the development of course content and approaches to delivery (see Recommendation 6.19)

- Online safety education for parents and other community members to better support children's safety online. Building on their current work, the Office of the eSafety Commissioner should oversee the delivery of this education nationally (see Recommendation 6.20)
- Prevention education for tertiary students studying university, technical and further education, and vocational education and training courses before entering child-related occupations. This should aim to increase awareness and understanding of the prevention of child sexual abuse and potentially harmful sexual behaviours in children
- Information and help-seeking services to support people who are concerned they may be at risk of sexually abusing children. The design of these services should be informed by the Stop It Now! model implemented in Ireland and the United Kingdom
- Information and help seeking services for parents and other members of the community concerned that:
  - An adult they know may be at risk of perpetrating child sexual abuse
  - A child or young person they know may be at risk of sexual abuse or harm
  - A child they know may be displaying harmful sexual behaviours.

### **Recommendation 6.3**

The design and implementation of these initiatives should consider:

- Aligning with and linking to national strategies for preventing violence against adults and children, and strategies for addressing other forms of child maltreatment
- Tailoring and targeting initiatives to reach, engage and provide access to all communities, including children, Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse communities, people with disability, and regional and remote communities
- Involving children and young people in the strategic development, design, implementation and evaluation of initiatives
- Using research and evaluation to:
  - Build the evidence base for using best practices to prevent child sexual abuse and harmful sexual behaviours in children
- Guide the development and refinement of interventions, including the piloting and testing of initiatives before they are implemented.

## WHAT MAKES INSTITUTIONS SAFER FOR CHILDREN

### Recommendation 6.4

All institutions should uphold the rights of the child. Consistent with Article 3 of the United Nations Convention on the Rights of the Child, all institutions should act with the best interests of the child as a primary consideration. In order to achieve this, institutions should implement the Child Safe Standards identified by the Royal Commission.

### Recommendation 6.5

The Child Safe Standards are:

- 1** Child safety is embedded in institutional leadership, governance and culture
- 2** Children participate in decisions affecting them and are taken seriously
- 3** Families and communities are informed and involved
- 4** Equity is upheld and diverse needs are taken into account
- 5** People working with children are suitable and supported
- 6** Processes to respond to complaints of child sexual abuse are child focused
- 7** Staff are equipped with the knowledge, skills and awareness to keep children safe through continual education and training
- 8** Physical and online environments minimise the opportunity for abuse to occur
- 9** Implementation of the Child Safe Standards is continuously reviewed and improved
- 10** Policies and procedures document how the institution is child safe.

### Recommendation 6.6

Institutions should be guided by the following core components when implementing the Child Safe Standards:

**Standard 1:** Child safety is embedded in institutional leadership, governance and culture

- The institution publicly commits to child safety and leaders champion a child safe culture.
- Child safety is a shared responsibility at all levels of the institution.
- Risk management strategies focus on preventing, identifying and mitigating risks to children.

- Staff and volunteers comply with a code of conduct that sets clear behavioural standards towards children.
- Staff and volunteers understand their obligations on information sharing and recordkeeping.

**Standard 2:** Children participate in decisions affecting them and are taken seriously

- Children are able to express their views and are provided opportunities to participate in decisions that affect their lives.
- The importance of friendships is recognised and support from peers is encouraged, helping children feel safe and be less isolated.
- Children can access sexual abuse prevention programs and information.
- Staff and volunteers are attuned to signs of harm and facilitate child-friendly ways for children to communicate and raise their concerns.

**Standard 3:** Families and communities are informed and involved

- Families have the primary responsibility for the upbringing and development of their child and participate in decisions affecting their child.
- The institution engages in open, two-way communication with families and communities about its child safety approach and relevant information is accessible.
- Families and communities have a say in the institution's policies and practices.
- Families and communities are informed about the institution's operations and governance.

**Standard 4:** Equity is upheld and diverse needs are taken into account

- The institution actively anticipates children's diverse circumstances and responds effectively to those with additional vulnerabilities.
- All children have access to information, support and complaints processes.
- The institution pays particular attention to the needs of Aboriginal and Torres Strait Islander children, children with disability, and children from culturally and linguistically diverse backgrounds.

**Standard 5:** People working with children are suitable and supported

- Recruitment, including advertising and screening, emphasises child safety.
- Relevant staff and volunteers have Working With Children Checks.
- All staff and volunteers receive an appropriate induction and are aware of their child safety responsibilities, including reporting obligations.
- Supervision and people management have a child safety focus.

**Standard 6:** Processes to respond to complaints of child sexual abuse are child focused



- The institution has a child-focused complaint handling system that is understood by children, staff, volunteers and families.
- The institution has an effective complaint handling policy and procedure which clearly outline roles and responsibilities, approaches to dealing with different types of complaints and obligations to act and report.
- Complaints are taken seriously, responded to promptly and thoroughly, and reporting, privacy and employment law obligations are met.

**Standard 7:** Staff are equipped with the knowledge, skills and awareness to keep children safe through continual education and training

- Relevant staff and volunteers receive training on the nature and indicators of child maltreatment, particularly institutional child sexual abuse.
- Staff and volunteers receive training on the institution's child safe practices and child protection.
- Relevant staff and volunteers are supported to develop practical skills in protecting children and responding to disclosures.

**Standard 8:** Physical and online environments minimise the opportunity for abuse to occur

- Risks in the online and physical environments are identified and mitigated without compromising a child's right to privacy and healthy development.
- The online environment is used in accordance with the institution's code of conduct and relevant policies.

**Standard 9:** Implementation of the Child Safe Standards is continuously reviewed and improved

- The institution regularly reviews and improves child safe practices.
- The institution analyses complaints to identify causes and systemic failures to inform continuous improvement.

**Standard 10:** Policies and procedures document how the institution is child safe

- Policies and procedures address all Child Safe Standards.
- Policies and procedures are accessible and easy to understand.
- Best practice models and stakeholder consultation inform the development of policies and procedures.
- Leaders champion and model compliance with policies and procedures.
- Staff understand and implement the policies and procedures.

## **IMPROVING CHILD SAFE APPROACHES**

*Council of Australian Governments*

### **Recommendation 6.7**

The national Child Safe Standards developed by the Royal Commission and listed at Recommendation 6.5 should be adopted as part of the new National Statement of Principles for Child Safe Organisations described by the Community Services Ministers' Meeting in November 2016. The National Statement of Principles for Child Safe Organisations should be endorsed by the Council of Australian Governments.

State and territory governments

### **Recommendation 6.8**

State and territory governments should require all institutions in their jurisdictions that engage in child-related work to meet the Child Safe Standards identified by the Royal Commission at Recommendation 6.5.

### **Recommendation 6.9**

Legislative requirements to comply with the Child Safe Standards should cover institutions that provide:

- Accommodation and residential services for children, including overnight excursions or stays
- Activities or services of any kind, under the auspices of a particular religious denomination or faith, through which adults have contact with children
- Childcare or childminding services
- Child protection services, including out-of-home care
- Activities or services where clubs and associations have a significant membership of, or involvement by, children
- Coaching or tuition services for children
- Commercial services for children, including entertainment or party services, gym or play facilities, photography services, and talent or beauty competitions
- Services for children with disability
- Education services for children
- Health services for children
- Justice and detention services for children, including immigration detention facilities
- Transport services for children, including school crossing services.

### **Recommendation 6.10**

State and territory governments should ensure that:

- An independent oversight body in each state and territory is responsible for monitoring and enforcing the Child Safe Standards. Where appropriate, this should be an existing body.
- The independent oversight body is able to delegate responsibility for monitoring and enforcing the Child Safe Standards to another state or territory government body, such as a sector regulator.

- Regulators take a responsive and risk-based approach when monitoring compliance with the Child Safe Standards and, where possible, utilise existing regulatory frameworks to monitor and enforce the Child Safe Standards.

### **Recommendation 6.11**

Each independent state and territory oversight body should have the following additional functions:

- Provide advice and information on the Child Safe Standards to institutions and the community
- Collect, analyse and publish data on the child safe approach in that jurisdiction and provide that data to the proposed National Office for Child Safety
- Partner with peak bodies, professional standards bodies and/or sector leaders to work with institutions to enhance the safety of children
- Provide, promote or support education and training on the Child Safe Standards to build the capacity of institutions to be child safe
- Coordinate ongoing information exchange between oversight bodies relating to institutions' compliance with the Child Safe Standards.

## **LOCAL GOVERNMENT**

### **Recommendation 6.12**

With support from governments at the national, state and territory levels, local governments should designate child safety officer positions from existing staff profiles to carry out the following functions:

- Developing child safe messages in local government venues, grounds and facilities
- Assisting local institutions to access online child safe resources
- Providing child safety information and support to local institutions on a needs basis
- Supporting local institutions to work collaboratively with key services to ensure child safe approaches are culturally safe, disability aware and appropriate for children from diverse backgrounds.

## **AUSTRALIAN GOVERNMENT**

### **Recommendation 6.13**

The Australian Government should require all institutions that engage in child-related work for the Australian Government, including Commonwealth agencies, to meet the Child Safe Standards identified by the Royal Commission at Recommendation 6.5.

### **Recommendation 6.14**

The Australian Government should be responsible for the following functions:

- Evaluate, publicly report on, and drive the continuous improvement of the implementation of the Child Safe Standards and their outcomes
- Coordinate the direct input of children and young people into the evaluation and continuous improvement of the Child Safe Standards
- Coordinate national capacity building and support initiatives and opportunities for collaboration between jurisdictions and institutions
- Develop and promote national strategies to raise awareness and drive cultural change in institutions and the community to support child safety.

## **NATIONAL FRAMEWORK FOR CHILD SAFETY**

### **Recommendation 6.15**

The Australian Government should develop a new National Framework for Child Safety in collaboration with state and territory governments. The Framework should:

- Commit governments to improving the safety of all children by implementing long-term child safety initiatives, with appropriate resources, and holding them to account
- Be endorsed by the Council of Australian Governments and overseen by a joint ministerial body
- Commence after the expiration of the current National Framework for Protecting Australia's Children, no later than 2020
- Cover broader child safety issues, as well as specific initiatives to better prevent and respond to institutional child sexual abuse including initiatives recommended by the Royal Commission
- Include links to other related policy frameworks.

## **NATIONAL OFFICE FOR CHILD SAFETY**

### **Recommendation 6.16**

The Australian Government should establish a National Office for Child Safety in the Department of the Prime Minister and Cabinet, to provide a response to the implementation of the Child Safe Standards nationally, and to develop and lead the proposed National Framework for Child Safety. The Australian Government should transition the National Office for Child Safety into an Australian Government statutory body within 18 months of this Royal Commission's Final Report being tabled in the Australian Parliament.

### **Recommendation 6.17**

The National Office for Child Safety should report to Parliament and have the following functions:

- Develop and lead the coordination of the proposed National Framework for Child Safety, including national coordination of the Child Safe Standards

- Collaborate with state and territory governments to lead capacity building and continuous improvement of child safe initiatives through resource development, best practice material and evaluation
- Promote the participation and empowerment of children and young people in the National Framework and child safe initiatives
- Perform the Australian Government's Child Safe Standards functions as set out at Recommendation 6.15
- Lead the community prevention initiatives as set out in Recommendation 6.2. Recommendation 6.18 The Australian Government should create a ministerial portfolio with responsibility for children's policy issues, including the National Framework for Child Safety.

## **PREVENTING AND RESPONDING TO ONLINE CHILD SEXUAL ABUSE IN INSTITUTIONS**

### **Recommendation 6.19**

Ministers for education, through the Council of Australian Governments, should establish a nationally consistent curriculum for online safety education in schools. The Office of the eSafety Commissioner should be consulted on the design of the curriculum and contribute to the development of course content and approaches to delivery. The curriculum should:

- Be appropriately staged from Foundation year to Year 12 and be linked with related content areas to build behavioural skills as well as technical knowledge to support a positive and safe online culture
- Involve children and young people in the design, delivery and piloting of new online safety education, and update content annually to reflect evolving technologies, online behaviours and evidence of international best practice approaches
- Be tailored and delivered in ways that allow all Australian children and young people to reach, access and engage with online safety education, including vulnerable groups that may not access or engage with the school system.

### **Recommendation 6.20**

Building on its current work, the Office of the eSafety Commissioner should oversee the delivery of national online safety education aimed at parents and other community members to better support children's safety online. These communications should aim to:

- Keep the community up to date on emerging risks and opportunities for safeguarding children online
- Build community understanding of responsibilities, legalities and the ethics of children's interactions online

- Encourage proactive responses from the community to make it 'everybody's business' to intervene early, provide support or report issues when concerns for children's safety online are raised
- Increase public awareness of how to access advice and support when online incidents occur.

### **Recommendation 6.21**

Pre-service education and in-service staff training should be provided to support child-related institutions in creating safe online environments. The Office of the eSafety Commissioner should advise on and contribute to program design and content. These programs should be aimed at:

- Tertiary students studying university, technical and further education, and vocational education and training courses, before entering child-related occupations; and could be provided as a component of a broader program of child sexual abuse prevention education (see Recommendation 6.2)
- Staff and volunteers in schools and other child-related organisations, and could build on the existing web-based learning programs of the Office of the eSafety Commissioner.

### **Recommendation 6.22**

In partnership with the proposed National Office of Child Safety (see Recommendations 6.16 and 6.17), the Office of the eSafety Commissioner should oversee the development of an online safety framework and resources to support all schools in creating child safe online environments. This work should build on existing school-based e-safety frameworks and guidelines, drawing on Australian and international models.

The school-based online safety framework and resources should be designed to:

- Support schools in developing, implementing and reviewing their online codes of conduct, policies and procedures to help create an online culture that is safe for children
- Guide schools in their response to specific online incidents, in coordination with other agencies. This should include guidance in complaint handling, understanding reporting requirements, supporting victims to minimise further harm, and preserving digital evidence to support criminal justice processes.

### **Recommendation 6.23**

State and territory education departments should consider introducing centralised mechanisms to support government and non-government schools when online incidents occur. This should result in appropriate levels of escalation and effective engagement with all relevant entities, such as the Office of the eSafety Commissioner, technical service providers and law enforcement.

Consideration should be given to:

- Adopting the promising model of the Queensland Department of Education and Training's Cyber Safety and Reputation Management Unit, which provides advice and a centralised coordination function for schools, working in partnership with relevant entities to remove offensive online content and address other issues
- Strengthening or re-establishing multi-stakeholder forums and case-management for effective joint responses involving all relevant agencies, such as police, education, health and child protection.

### **Recommendation 6.24**

In consultation with the eSafety Commissioner, police commissioners from states and territories and the Australian Federal Police should continue to ensure national capability for coordinated, best practice responses by law enforcement agencies to online child sexual abuse. This could include through:

- Establishing regular meetings of the heads of cyber safety units in all Australian police departments to ensure a consistent capacity to respond to emerging incidents and share best practice approaches, tools and resources
- Convening regular forums and conferences to bring together law enforcement, government, the technology industry, the community sector and other relevant stakeholders to discuss emerging issues, set agendas and identify solutions to online child sexual abuse and exploitation
- Building capability across police departments, through in-service training for:
- Frontline police officers to respond to public complaints relating to issues of online child sexual abuse or harmful sexual behaviours
- Police officers who liaise with young people in school and community settings.

## **VOLUME 10 – CHILDREN WITH HARMFUL SEXUAL BEHAVIOURS RECOMMENDATIONS**

### **A FRAMEWORK FOR IMPROVING RESPONSES**

#### **Recommendation 10.1**

The Australian Government and state and territory governments should ensure the issue of children's harmful sexual behaviours is included in the national strategy to prevent child sexual abuse that we have recommended (see Recommendations 6.1 to 6.3).

Harmful sexual behaviours by children should be addressed through each of the following:

- primary prevention strategies to educate family, community members, carers and professionals (including mandatory reporters) about preventing harmful sexual behaviours
- secondary prevention strategies to ensure early intervention when harmful sexual behaviours are developing
- tertiary intervention strategies to address harmful sexual behaviours.

## **IMPROVING ASSESSMENT AND THERAPEUTIC INTERVENTION**

### **Recommendation 10.2**

The Australian Government and state and territory governments should ensure timely expert assessment is available for individual children with problematic and harmful sexual behaviours, so they receive appropriate responses, including therapeutic interventions, which match their particular circumstances.

### **Recommendation 10.3**

The Australian Government and state and territory governments should adequately fund therapeutic interventions to meet the needs of all children with harmful sexual behaviours. These should be delivered through a network of specialist and generalist therapeutic services. Specialist services should also be adequately resourced to provide expert support to generalist services.

### **Recommendation 10.4**

State and territory governments should ensure that there are clear referral pathways for children with harmful sexual behaviours to access expert assessment and therapeutic intervention, regardless of whether the child is engaging voluntarily, on the advice of an institution or through their involvement with the child protection or criminal justice systems.

### **Recommendation 10.5**

Therapeutic intervention for children with harmful sexual behaviours should be based on the following principles:

- A contextual and systemic approach should be used
- Family and carers should be involved
- Safety should be established
- There should be accountability and responsibility for the harmful sexual behaviours
- There should be a focus on behaviour change
- Developmentally and cognitively appropriate interventions should be used
- The care provided should be trauma-informed
- Therapeutic services and interventions should be culturally safe
- Therapeutic interventions should be accessible to all children with harmful sexual behaviours.



## **STRENGTHENING THE WORKFORCE**

### **Recommendation 10.6**

The Australian Government and state and territory governments should ensure that all services funded to provide therapeutic intervention for children with harmful sexual behaviours provide professional training and clinical supervision for their staff.

## **IMPROVING EVALUATION**

### **Recommendation 10.7**

The Australian Government and state and territory governments should fund and support evaluation of services providing therapeutic interventions for problematic and harmful sexual behaviours by children.

## **VOLUME 12 – CONTEMPORARY OUT-OF-HOME CARE RECOMMENDATIONS**

## **DATA COLLECTION AND REPORTING**

### **Recommendation 12.1**

The Australian Government and state and territory governments should develop nationally agreed key terms and definitions in relation to child sexual abuse for the purpose of data collection and reporting by the Australian Institute of Health and Welfare (AIHW) and the Productivity Commission.

### **Recommendation 12.2**

The Australian Government and state and territory governments should prioritise enhancements to the Child Protection National Minimum Data Set to include:

- Data identifying children with disability, children from culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander children
- The number of children who were the subject of a substantiated report of sexual abuse while in out-of-home care
- The demographics of those children
- The type of out-of-home care placement in which the abuse occurred
- Information about when the abuse occurred
- Information about who perpetrated the abuse, including their age and their relationship to the victim, if known.

### **Recommendation 12.3**

State and territory governments should agree on reporting definitions and data requirements to enable reporting in the Report on government services on outcome indicators for 'improved health and wellbeing of the child', 'safe return home' and 'permanent care'.

## **ACCREDITATION OF OUT-OF-HOME CARE SERVICE PROVIDERS**

### **Recommendation 12.4**

Each state and territory government should revise existing mandatory accreditation schemes to:

- Incorporate compliance with the Child Safe Standards identified by the Royal Commission
- Extend accreditation requirements to both government and non-government out-of-home care service providers.

### **Recommendation 12.5**

In each state and territory, an existing statutory body or office that is independent of the relevant child protection agency and out-of-home care service providers, for example a children's guardian, should have responsibility for:

- Receiving, assessing and processing applications for accreditation of out-of-home care service providers
- Conducting audits of accredited out-of-home care service providers to ensure ongoing compliance with accreditation standards and conditions.

## **CARER AUTHORISATION**

### **Recommendation 12.6**

In addition to a National Police Check, Working With Children Check and referee checks, authorisation of all foster and kinship/relative carers and all residential care staff should include:

- Community services checks of the prospective carer and any adult household members of home-based carers
- Documented risk management plans to address any risks identified through community services checks
- At least annual review of risk management plans as part of carer reviews and more frequently as required.

### **Recommendation 12.7**

All out-of-home care service providers should conduct annual reviews of authorised carers that include interviews with all children in the placement with the carer under review, in the absence of the carer.

### **Recommendation 12.8**

Each state and territory government should adopt a model of assessment appropriately tailored for kinship/relative care. This type of assessment should be designed to:

- Better identify the strengths as well as the support and training needs of kinship/relative carers

- Ensure holistic approaches to supporting placements that are culturally safe
- Include appropriately resourced support plans.

## **CHILD SEXUAL ABUSE EDUCATION STRATEGY**

### **Recommendation 12.9**

All state and territory governments should collaborate in the development of a sexual abuse prevention education strategy, including online safety, for children in out-of-home care that includes:

- Input from children in out-of-home care and care-leavers
- Comprehensive, age-appropriate and culture-appropriate education about sexuality and healthy relationships that is tailored to the needs of children in out-of-home care
- Resources tailored for children in care, for foster and kinship/relative carers, for residential care staff and for caseworkers
- Resources that can be adapted to the individual needs of children with disability and their carers.

## **CREATING A CULTURE THAT SUPPORTS DISCLOSURE AND IDENTIFICATION OF CHILD SEXUAL ABUSE**

### **Recommendation 12.10**

State and territory governments, in collaboration with out-of-home care service providers and peak bodies, should develop resources to assist service providers to:

- Provide appropriate support and mechanisms for children in out-of-home care to communicate, either verbally or through behaviour, their views, concerns and complaints
- Provide appropriate training and support to carers and caseworkers to ensure they hear and respond to children in out-of-home care, including ensuring children are involved in decisions about their lives
- Regularly consult with the children in their care as part of continuous improvement processes.

## **STRENGTHENING THE CAPACITY OF CARERS, STAFF AND CASEWORKERS TO SUPPORT CHILDREN**

### **Recommendation 12.11**

State and territory governments and out-of-home care service providers should ensure that training for foster and relative/kinship carers, residential care staff and child protection workers includes an understanding of trauma and abuse, the impact on children and the principles of trauma-informed care to assist them to meet the needs of children in out-of-home care, including children with harmful sexual behaviours.

## **IDENTIFYING, ASSESSING AND SUPPORTING CHILDREN WITH HARMFUL SEXUAL BEHAVIOURS**

### **Recommendation 12.12**

When placing a child in out-of-home care, state and territory governments and out-of-home care service providers should take the following measures to support children with harmful sexual behaviours:

- Undertake professional assessments of the child with harmful sexual behaviours, including identifying their needs and appropriate supports and interventions to ensure their safety
- Establish case management and a package of support services
- Undertake careful placement matching that includes:
- Providing sufficient relevant information to the potential carer/s and residential care staff to ensure they are equipped to support the child, and additional training as necessary
- Rigorously assessing potential threats to the safety of other children, including the child's siblings, in the placement.

### **Recommendation 12.13**

State and territory governments and out-of-home care service providers should provide advice, guidelines and ongoing professional development for all foster and kinship/relative carers and residential care staff about preventing and responding to the harmful sexual behaviours of some children in out-of-home care.

## **PREVENTING AND RESPONDING TO CHILD SEXUAL EXPLOITATION**

### **Recommendation 12.14**

All state and territory governments should develop and implement coordinated and multi-disciplinary strategies to protect children in residential care by:

- Identifying and disrupting activities that indicate risk of sexual exploitation
- Supporting agencies to engage with children in ways that encourage them to assist in the investigation and prosecution of sexual exploitation offences.

### **Recommendation 12.15**

Child protection departments in all states and territories should adopt a nationally consistent definition for child sexual exploitation to enable the collection and reporting of data on sexual exploitation of children in out-of-home care as a form of child sexual abuse.

## **INCREASING THE STABILITY OF PLACEMENTS**

### **Recommendation 12.16**

All institutions that provide out-of-home care should develop strategies that increase the likelihood of safe and stable placements for children in care. Such strategies should include:

- Improved processes for 'matching' children with carers and other children in a placement, including in residential care
- The provision of necessary information to carers about a child, prior to and during their placement, to enable carers to properly support the child
- Support and training for carers to deal with the different developmental needs of children as well as managing difficult situations and challenging behaviour.

## **SUPPORTING KINSHIP/RELATIVE CARE PLACEMENTS**

### **Recommendation 12.17**

Each state and territory government should ensure that:

- The financial support and training provided to kinship/relative carers is equivalent to that provided to foster carers
- The need for any additional supports are identified during kinship/relative carer assessments and are funded
- Additional casework support is provided to maintain birth family relationships.

## **RESIDENTIAL CARE**

### **Recommendation 12.18**

The key focus of residential care for children should be based on an intensive therapeutic model of care framework designed to meet the complex needs of children with histories of abuse and trauma.

### **Recommendation 12.19**

All residential care staff should be provided with regular training and professional supervision by appropriately qualified clinicians.

## **ABORIGINAL AND TORRES STRAIT ISLANDER CHILDREN**

### **Recommendation 12.20**

Each state and territory government, in consultation with appropriate Aboriginal and Torres Strait Islander organisations and community representatives, should develop and implement plans to:

- Fully implement the Aboriginal and Torres Strait Islander Child Placement Principle

- Improve community and child protection sector understanding of the intent and scope of the principle
- Develop outcome measures that allow quantification and reporting on the extent of the full application of the principle, and evaluation of its impact on child safety and the reunification of Aboriginal and Torres Strait Islander children with their families
- Invest in community capacity building as a recognised part of kinship care, in addition to supporting individual carers, in recognition of the role of Aboriginal and Torres Strait Islander communities in bringing up children.

## **CHILDREN WITH DISABILITY**

### **Recommendation 12.21**

Each state and territory government should ensure:

- The adequate assessment of all children with disability entering out-of-home care
- The availability and provision of therapeutic support
- Support for disability-related needs
- The development and implementation of care plans that identify specific risk-management and safety strategies for individual children, including the identification of trusted and safe adults in the child's life.

## **CARE-LEAVERS**

### **Recommendation 12.22**

State and territory governments should ensure that the supports provided to assist all care-leavers to safely and successfully transition to independent living include:

- Strategies to assist care-leavers who disclose that they were sexually abused while in out-of-home care to access general post-care supports
- The development of targeted supports to address the specific needs of sexual abuse survivors, such as help in accessing therapeutic treatment to deal with impacts of abuse, and for these supports to be accessible until at least the age of 25.