Working Together for Families

Child Protection in the AOD Service Context

KAMIRA

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About this resource

The NADA grant program was a key component of the Women's AOD Service Development Program funded by the Commonwealth Department of Health to support improved capacity of alcohol and other drug (AOD) non-government services to meet the needs of substance using women with and without children.

The purpose of this resource is to provide AOD service providers with essential knowledge about child protection processes. The resource aims to enhance the working relationships between AOD services and child protection services involved with women with children in the AOD context. While this resource was developed for use by the non-government AOD sector in NSW, the information in it is relevant for, and could be used by, organisations that work with women with children involved with AOD services.

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About Kamira

Kamira provides AOD treatment services for women with or without children across the state of NSW, Australia.

Kamira provides a place of enduring value for women and families to support them to thrive beyond dependency. Kamira believes that everybody has the ability to recover. Everybody has the right to access quality treatment. That building strong relationships with family and significant others is the foundation to long lasting recovery.

Based in Wyong on the Central Coast of NSW, Kamira provides residential and outreach services for women with or without children, and their family and significant others.

Further information about Kamira, its programs and services is available on the Kamira website at www.kamira.com.au.

KAMIRA

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Members of the NADA Women's AOD Services Network that include:

- Detour House Inc.
- Dianella Cottage
- Guthrie House
- Jarrah House, Women's Alcohol and Drug Advisory Centre
- Kamira
- Kathleen York House, Alcohol and Drug Foundation NSW
- Phoebe House
- Sydney Women's Counselling Centre
- New Beginnings, We Help Ourselves

Resource Development

Alison Bell, Bell Mental Health Training Pty Ltd

Acronyms

ACFC	Aboriginal Child and Family Centres
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and Other Drug
CAG	Council of Australian Governments
CSC	Community Services Centre FaCS
CW	Caseworker FaCS
CWS	Caseworker Specialist FaCS
EIPP	Early Intervention & Placement Prevention
FaCS	Family and Community Services
FASD	Foetal Alcohol Spectrum Disorder
FRS	Family Referral Service
JIRT	Joint Investigation Response Team
MCS	Manager Client Services FaCS
MCW	Manager Caseworker FaCS
NADA	Network of Alcohol and other Drugs Agencies
NCETA	National Centre for Education and Training on Addiction
NDARC	National Drug and Alcohol Research Centre
NGO	Non-government organisation
NOFASD	National Organisation for Foetal Alcohol Spectrum Disorder
OOHC	Out of Home Care
OSP	Office of the Senior Practitioner
PUP	Parents Under Pressure
ROSH	Risk of significant harm
SDM	Structured Decision Making
WFT	Whole of Family Team

Contents

Purpose of this resource

Safety and security don't just happen, they are the result of collective consensus and public investment. We owe our children, the most vulnerable citizens in our society, a life free of violence and fear (Nelson Mandela).

Parents with AOD use issues can significantly impact on the wellbeing of dependent children. Parents are frequently involved with AOD treatment services, with or without their children in their care. The involvement of child protection services can lead to significant change for parents and their children.

It is essential that professionals working with parents of dependent children have a thorough and up-to-date understanding of the legislation, processes, procedures and relevant guidelines. AOD service workers need to focus on the needs of the children and family and to work collaboratively with other services such as Family and Community Services (FaCS).

The purpose of this resource is firstly to provide key information to AOD service workers engaged with substance using parents with dependent children. The resource also aims to provide a framework for more effective collaboration between AOD services and child protection services. Included in this resource are links to relevant resources and guidelines for informing practice. It is hoped that the information in this resource will ultimately have a positive impact on the lives of children whose parents are involved with significant AOD use.

Background

The past decades have seen a heightened awareness of the needs of children in our community. Nationally, in 2010-2011 there were 237,273 notifications involving 163,767 children at risk, a rate of almost 32 in 1,000 children. Of the notifications, 54% were investigated with 40,466 substantiations of a child considered to be at risk – a rate of 6.1 per 1,000 Australian children (AIHW, 2012).

The impact of parental AOD use issues on dependent children has been well-documented in many reports into child abuse, neglect and death. Parental AOD use is considered to be one of the key factors in recent child death reviews (NSW Child Death Review Team, 2012, 2013, 2014). In 2008–2009, estimates of the prevalence of substance abuse problems amongst parents who have contact with child protection services ranged from 50% to 80%. Reviews of case files of families reported to NSW Community Services indicated that in 41% of cases, at least one parent was known to misuse drugs, and in 46% of cases, alcohol misuse was reported (NSW Community Services, 2010).

There are multiple factors that contribute to risk of harm for children, including poverty, mental illness, domestic violence, gambling and AOD issues, with many of these factors overlapping. "Parental substance use is likely to be a marker for the presence of, as well as compounding the effects of, other risk factors" (NSW Community Services 2010). It is, of course, important to view AOD use issues and any impact this may have on parenting capacity within context rather than assuming that AOD use is the causal factor (Dawe, Harnett and Frye, 2008).

The impact of maternal AOD use on the unborn child has also been increasingly in focus. Awareness of the effects of alcohol and the possibility of resultant foetal alcohol spectrum disorder (FASD) has led to increasing levels of concern (Bonello, Hilder and Sullivan, 2014). The impact of other drug use during pregnancy and the potential for lifelong effects on children has led to the development of government strategies and guidelines for healthcare providers (NSW Health, 2014; NDARC, 2014).

There are potentially a number of significant risks for dependent children of parents. with AOD use issues. Parenting capacity can be impacted by AOD use itself, along with commonly co-occuring factors such as unemployment, poverty, housing instability and social isolation. Children's medical, nutritional, social and emotional needs are more commonly neglected. Family violence is more common in households where there is significant use of AOD (NSW Community Services, 2010).

Given the links between parents living with AOD use issues and risk of harm to children, there has been an increasing focus on working with parents to address their AOD use concerns. The involvement of child protection services can be a critical trigger for parents to enter into AOD treatment, often with the hope of regaining custody of their children (Battams et al., 2010; Breen, Awbery and Burns, 2014).

Services, such as AOD treatment providers and FaCS, working with families at risk have traditionally tended to work separately.

There have been increasing moves towards a more integrated approach to working with families at risk, and

the call for greater transparency and collaboration between services (Gruenert and Tsantefski, 2012; Council of Australian Governments, 2009; NSW Community Services, 2006). As one NADA Network member stated:

> "If there was a collective approach (with FACS) we could support them and the children instead of waiting until there is a crisis. That is a missed opportunity to work with the family… to work with children as well"
>
> (Jenner, Lee, Cameron and Harney, 2014; p.42)

The National Framework for Protecting Australia's Children 2009–2020 highlights the need for a move away from 'seeing protecting children merely as a response to abuse and neglect to one of promoting safety and wellbeing of children' and calls for a public health model, focusing on universal supports for families to be adopted (Council of Australian Governments COAG, 2009, p. 6). This resource therefore, highlights a number of ways in which AOD services can make a difference to the safety and wellbeing of children.

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1 IMPACT OF PARENTAL AOD USE ON CHILDREN

There are multiple factors that can contribute to the impact of parental AOD use on dependent children.

AOD use issues can compound the effects of other issues such as mental health, family violence, poverty and social disadvantage (Bromfield et al., 2010). "It is generally difficult to disentangle the effects of parental substance use from broader social and economic factors that contribute to and maintain the misuse of either drugs or alcohol (Dawe et al., 2007, p. viii)

Australian studies estimate that around 10 to 13% of children are affected by parental AOD misuse. Around 1.5% of children have a parent attending drug treatment services (Battams et al, 2010). International research suggests that substance abuse is implicated in at least 50% of families identified by child protection services (Dawe et al., 2007), whilst Australian studies have found that up to 80% of child notifications involved parents affected by AOD misuse (Ainsworth, 2004). A report from the South Australian Community Services estimated that parental AOD use was linked to as many as 70% of cases where children entered into out-of-home care arrangements (Jeffreys et al., 2008).

1.1 Specific Risk Factors for Children

Risk of harm to children can occur due to a range of complex interacting factors. However, parental AOD use does not automatically mean that children will be abused or neglected. However, there are a range of well-documented impacts that significant and persistent parental AOD use can have on dependent children.

- The direct effect of intoxication and withdrawal can impact on a parent's capacity to provide adequate care and supervision of children. Intoxication can impair an adult's ability to prepare a meal, maintain routines such as school attendance and can impact on their capacity to respond to the child's emotional and safety needs. The effects of intoxication and withdrawal can also lead to inconsistency in disciplinary strategies.
- The nature of the substances used will impact on parenting ability. Sedating drugs, such as alcohol, opiates or benzodiazepines or a combination of these, can severely impact on a parent's alertness to the needs of children. Stimulant-type substances such as methamphetamine can lead to issues such as severe mood swings and hostility during intoxication, long periods of being awake during use, followed by significant periods of needing to sleep during withdrawal, all of which can impact on a parent's capacity to supervise children.
- Involvement with illegal activity, injecting and other equipment, association with other adults who use AOD and the possibility of exposure to drug manufacturing equipment can all impact on the safety of dependent children.
- Co-occurring mental health and AOD issues in a parent will significantly increase the risk of harm to children. Issues such as mood swings, episodes of psychosis, bouts of depression, significant anxiety, mixed with the effects of AOD, can result in significant impacts on a child's physical, social and emotional wellbeing.
- Financial disadvantage is likely to be a factor in households where there is significant drug use. This will have an impact on children in multiple ways including housing instability, nutritional intake, involvement with school and outside activities.
- Social isolation can result from significant parental AOD use. AOD using parents can be disconnected from their extended family and feel excluded from mainstream social support. This is particularly the case where the family frequently moves location.

(Sources: Dawe, Harnett and Frye, 2008; Bromfield, et al., 2010).

It is also important to focus on protective factors that can mitigate the above impacts on children. Protective factors include connectedness to extended family, involvement with school and communities and social services. One Australian study found that involvement with AOD treatment programs, including pharmacotherapy programs, can make a significant difference to reducing risk of harm for children (Taplin and Mattick, 2011).

Becoming pregnant can be a significant impetus for changing AOD use

1.2 Pregnancy and AOD Use

It has been well-documented that AOD use during pregnancy can have significant and long-lasting impacts on a child. Information about alcohol and other drug use during pregnancy is not adequately collected in Australia. Surveys estimate that 50-80% of pregnant women continue to drink, the majority at low levels. A small proportion of women continue to drink at risky levels. Although the proportion of women that smoke during pregnancy has also declined, around 49% of Indigenous Australian women and 12% of non-Indigenous women continue to do so (NDARC, 2014).

Among pregnant women who use illicit drugs, opiate use remains most prevalent. However, use of other drugs, such as methamphetamine, is of increasing concern due to their impact on women's mental and physical health and the heightened risk they pose for obstetric complications (Taylor et al., 2012).

Becoming pregnant can be a significant impetus for changing AOD use. There are a number of studies that have shown that treatment seeking is significantly increased when substance using women become pregnant (Greenfield et al., 2007, Mitchell et al., 2008, Jackson & Shannon, 2012).

Societal attitudes towards women with a history of substance misuse who are pregnant tend to be very negative, attitudes that are sometimes reflected within maternal health service workers. Unfortunately this may prevent pregnant women from seeking prenatal support due to the fear of negativity from health providers; "Such is the stigma and guilt associated with alcohol use during pregnancy that only a minority of pregnant women with alcohol use disorders access treatment." (Burns and Breen, 2013).

It is imperative that pregnant women with AOD issues receive services that can support them throughout their pregnancy and provide post-natal support for themselves and their baby. A recent NDARC report into the importance of supporting women who are pregnant who use AOD concluded that:

- being pregnant, or the possibility of being pregnant, may provide additional motivation to adress AOD use issues.
- women with problematic substance use require additional support to cease or reduce their consumption during pregnancy.
- support must be comprehensive and address the range of health, mental health and social factors that affect women's wellbeing.
- evidence shows that well-coordinated and comprehensive support with early access to antenatal care and specialist AOD treatment can reduce harm and improve outcomes for pregnant women who have problematic AOD use, and their babies (Breen, Awbery and Burns, 2014).

For further information refer to the following documents:

- Clinical Guidelines for the Management of Substance use During Pregnancy, Birth and the Postnatal Period. (NSW Ministry of Health, 2014).
- It's time to have the conversation: Understanding the treatment needs of women who are pregnant and alcohol dependent. (Burns and Breen, 2013).
- Supporting pregnant women who use alcohol or other drugs: A review of the evidence (Breen, Awbery and Burns, 2014).
- National Organisation for Fetal Alcohol Spectrum Disorder: NOFASD
  Website: www.nofasd.org.au

1.3 Potential Signs of Abuse or Neglect in Children

There are multiple signs that might indicate that a child is at risk of harm. It is important to remember that most of the signs listed in the reports below do not automatically indicate child abuse or neglect. It is also the presence of multiple signs that may indicate risk of serious harm to children. The child or young person's circumstances and their age or other vulnerabilities, for example disability or chronic illness, also need to be taken into consideration.

For a list of possible signs of child abuse or neglect refer to: www.community.nsw.gov.au/docs_menu/preventing_child_abuse_and_neglect/what_is_child_abuse/signs_of_abuse.html

Due to the impact of significant parental AOD use on the risk of neglect and harm for children, it is imperative that AOD service workers be aware of the risks for children, be involved in routinely screening for risk to children of adults presenting to AOD services, and work collaboratively with child protection services to address the risk of significant harm to children.

2 UNDERSTANDING CHILD PROTECTION

We must organise around our best hopes not our worst fears (Turnell, 1999)

The rate of reports of child abuse and neglect has more than doubled over the past 10 years. Indigenous children continue to be over-represented in regards to substantiated cases of abuse or neglect. Some of the increase in reporting of child abuse and neglect are a result of changing social values and knowledge about the safety and wellbeing of children (COAG, 2009).

The types of risks to children being reported have changed over time in response to community expectations. They are now likely to include physical abuse, sexual abuse, emotional abuse, neglect, family violence. Emotional abuse and neglect are now the most commonly substantiated types of child maltreatment, followed by physical abuse (AIHW, 2012).

The national recurrent expenditure on child protection and out-of-home care services was approximately $2.8 billion in 2010–11, a real increase of $137.7 million (5.1%) from 2009–10 (AIHW, 2012).

2.1 Child Protection in Australia

Whilst child protection services operate at the state and territory level, there is an overarching national focus on child wellbeing. The National Framework for Protecting Australia's Children 2009–2020 (COAG, 2009) clearly states that "protecting children is everyone's responsibility. Parents, communities, governments and business all have a role to play" (COAG, 2009, p. 4).

As Australia is a signatory to the United Nations Convention on the Rights of the Child, the National Framework is under-pinned by the following principles:

- all children have a right to grow up in an environment free from neglect and abuse. Their best interests are paramount in all decisions affecting them.
- children and their families have a right to participate in decisions affecting them.
- improving the safety and wellbeing of children is a national priority.
- the safety and wellbeing of children is primarily the responsibility of their families, who should be supported by their communities and governments.
- Australian society values, supports and works in partnership with parents, families and others in fulfilling their caring responsibilities for children.
- children's rights are upheld by systems and institutions.
- policies and interventions are evidence based.

Within the National Framework, there are six supporting outcomes:

1. Children live in safe and supportive families and communities
2. Children and families access adequate support to promote safety and intervene early
3. Risk factors for child abuse and neglect are addressed
4. Children who have been abused or neglected receive the support and care they need for their safety and wellbeing
5. Indigenous children are supported and safe in their families and communities
6. Child sexual abuse and exploitation is prevented and survivors receive adequate support.

Figure 1 below provides a framework for the range of services nationally that need to be involved with ensuring child protection.

For a copy of the National Framework for Protecting Australia's Children 2009–2020:

https://www.dss.gov.au/sites/default/files/documents/child_protection_framework.pdf

"Protecting children is everyone's responsibility. Parents, communities, governments and business all have a role to play"

(CAG, 2009, p. 4).

Practice Point

Have you looked at the Children and Young Persons (Care and Protection) Act 1998 and amendments?

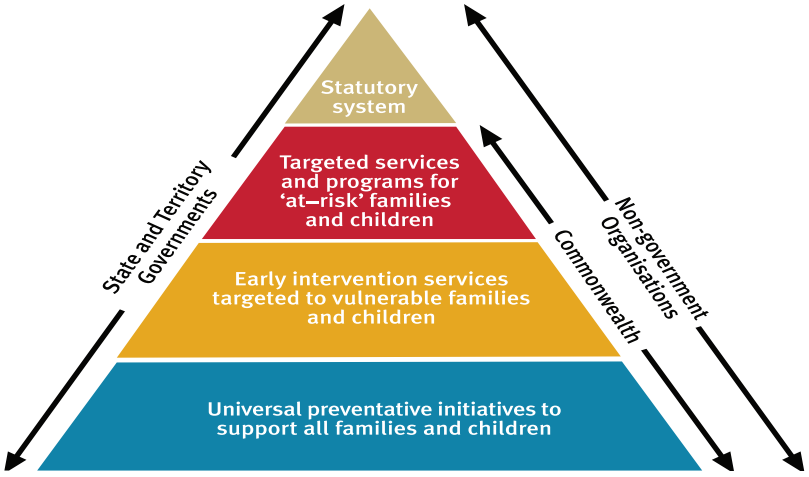
Do you understand the treatment needs of women who are pregnant and AOD dependent?

Are you aware of recent updates to the Act and the implications for AOD professionals working with parents and children?

How can you aid parents involved with child protection services to be more informed?

It is recommended that AOD workers involved with parents and children remain up to date in their

Figure 1. A system for protecting children



Source: National Framework for Protecting Australia's Children 2009–2020

2.1.1 CHILD PROTECTION LEGISLATION IN NSW

In NSW, child protection falls within the Children and Young Persons (Care and Protection) Act 1998. The Act and subsequent amendments provide the legislative framework to promote and ensure the safety, welfare and wellbeing of children and young people in NSW.

There are key sections within the Act that AOD workers need to be particularly aware of such as the section governing the exchange of information between services.

For a full copy of the Children and Young Persons (Care and Protection) Act 1998 and amendments:

www.legislation.nsw.gov.au/maintop/view/inforce/act+157+1998+cd+0+N

Understanding the Act

It can often be very confusing for parents who are involved with the Children's Court and child protection services. Helping clients to understand the relevant parts of the Act, their rights and responsibilities within the Act can be an essential task for AOD workers involved with parents. Resources have been developed to assist parents to understand what has happened and what may happen in the future in regards to their rights and responsibilities as a parent. Legal Aid NSW have developed six booklets in their Kids in Care series:

1. Community Services want to talk about my kids: what will happen?
2. Going to the Children's Court
3. Things have changed and I want my kids back: what can I do?
4. The Children's Court made a decision I am unhappy about: what can I do?
5. What happens when my kids are in care?
6. Aboriginal and Torres Strait Islander children and care.

www.legalaid.nsw.gov.au/publications/factsheets-and-resources/kids-in-care

Legal Aid also offer training on Law for Community Workers. For a list of workshops offered by Legal Aid:

www.legalaid.nsw.gov.au/what-we-do/workshops/law-for-community-workers

3 FAMILY AND COMMUNITY SERVICES

In NSW, child protection services are administered by Community Services which is within the NSW Department of Family and Community Services. Community Services operates within the legal framework set by the Children and Young Persons (Care and Protection) Act 1998, the Community Welfare Act 1987 and the Adoption Act 2000.

The past decade has seen a number of significant reforms in the area of child protection in response to a range of concerning issues. Reform of child protection services gained momentum following the Special Commission of Inquiry into Child Protection Services in 2008, resulting in NSW Community Services launching the Keep them Safe initiative. More recently, there have been further reforms within FaCS, including the Safe Home for Life initiative and the Care and Protection Practice Framework.

3.1 Roles and Responsibilities of Community Services

Community Services promotes the safety and wellbeing of children and young people and works to build stronger families and communities. Community Services provides services in child protection, parenting support and early intervention, out-of-home care (including adoption) and assistance for communities affected by disaster.

With the introduction of Keep Them Safe Community Services statutory child protection focus is now on children and young people who are at risk of significant harm.

Community Services' lead role does not detract from the joint responsibility of all relevant agencies to protect children and young people who are at risk of harm and to work together to provide a coordinated and comprehensive response. A stronger, more meaningful approach to collaboration and partnership between government, community organisations and the wider community is one of the key messages from Keep Them Safe.

Responsibilities of Community Services include:

- responding to requests for assistance from children, young people and families and receive and assess reports of children and young people at risk of significant harm
- plan, conduct and manage joint investigations of serious child sexual, physical abuse and extreme neglect reports with NSW Police and NSW Health when medical examinations are needed
- undertake risk, safety and needs assessments of children or young people, and their family, to ensure their safety, welfare and wellbeing
- provide, arrange and request care and support services for children, young people and families, including homeless children and young people
- initiate care proceedings in the Children's Court where there are serious risk and safety issues present
- provide, or negotiate with other agencies to provide high quality out-of-home care and support services to children and young people
- involve and promote Aboriginal and Torres Strait Islander people in the care and protection of their children and young people, including decision making, with as much self-determination as is possible
- raising community awareness about the safety, welfare and wellbeing of children and young people.

(Child Wellbeing and Child Protection – NSW Interagency Guidelines

www.community.nsw.gov.au/kts/roles)

For further information on Keep them Safe, including evaluation reports:

http://www.keepthemsafe.nsw.gov.au/about

"No matter what the theoretical model by which one human being attempts to be of help to another, the most potent and dynamic power for influence lies in the relationship"

(Pearlman 1972).

Practice Point

Do you have a clear understanding of FaCS' roles and responsibilities?

It is recommended that you display the FaCS Care and Protection Standards for clients to view within your service.

You can find a copy of the Practice Standards poster at the following website:

www.community.nsw.gov.au/__data/assets/pdf_file/0003/320988/practice_framework_a3.pdf

Practice Point

The Clinical Issues Team are available for consultation by a FaCS Caseworker, particularly when attempting to establish the extent to which a parent's serious and persistent AOD use issues may be impacting on a person's capacity to parent,

If issues around assessment of AOD use issues arise within a case conference with FaCS, ask if the Clinical Issues Team have been consulted.

3.2 Care and Protection Practice Framework

There has recently been a shift in the culture of FaCS at an organisational level under the banner of the Care and Protection Practice Framework, launched in December 2012. The Framework describes Community Services' mandate and approach to their work with children and families in NSW. It articulates the principles and values that underpin the Framework and clarifies the knowledge and skills that are required for good casework practice. The framework promotes building relationships to create change, which reflects a shift in practice within FaCS.

For a more detailed description of the Framework: www.community.nsw.gov.au/for-agencies-that-work-with-us/child-protection-services/care-and-protection-practice-framework

The framework is further supported by the Care and Protection Practice Standards which outline what families working with FaCS can expect from child protection caseworkers. The 10 Practice Standards within the Framework are:

1. Practice leadership
2. Relationship-based practice
3. Holistic assessment and family work
4. Collaboration
5. Critical reflection
6. Culturally responsive practice with Aboriginal communities
7. Culturally responsive practice with diverse communities
8. Practice expertise
9. Sharing risk
10. Documentation in casework

For a more detailed description of the Practice Standards:

www.facs.nsw.gov.au/__data/assets/file/0018/332244/practice_standards.pdf

3.2.1 OFFICE OF THE SENIOR PRACTITIONER (OSP)

In July 2012 FaCS established the OSP in the Community Services division to drive reforms that put the best interests of children and young people at the centre of everything FaCS does. The OSP works to promote good practice and inspire, support and review the work of child protection practitioners. The OSP also helps to ensure that fair, transparent and independent review of FaCS practice and decisions feeds back into ongoing improvement.

3.2.2 CLINICAL ISSUES TEAM

Within the FaCS OSP there is a specialist team, referred to as the Clinical Issues Team. The Clinical Issues Team provides specialist advice and support to practitioners in cases where pasrental AOD use issues, mental illness and/or domestic violence are impacting on the safety and wellbeing of children and young people. The Clinical Issues Team is staffed by a team of clinical professionals, all of whom have had significant clinical experience in AOD, mental health and domestic violence service provision in a range of health and NGO services.

The clinical consultants have allocated districts across NSW and cover the state in response to email, telephone and face-to-face requests for consultation and support. The team also promote interagency collaboration and encourage Community Services Centres' staff to invite their interagency partners to training sessions that the team conducts.

clinical.issues@facs.nsw.gov.au

An example of collaborative practice between FaCS and AOD services

Rebecca (42) had 4 children; Blake (16), Keisha (10), Luke (9) and Kane (4). Numerous reports had been made to FaCS over the years due to issues around parental drug misuse, mental ill health, neglect, physical and verbal abuse, lack of supervision and poor school attendance.

Rebecca had a long history of childhood trauma and experienced severe domestic violence and physical assault perpetrated by the children's father, David (45). David was incarcerated and had no contact with his children.

Rebecca also had a history of opioid, methamphetamine and cannabis misuse. She was on opioid treatment (methadone) through a local service. Rebecca reported using a small amount of cannabis to help her sleep at night and manage chronic pain from a long term back injury. Rebecca had a history of 'doctor shopping' for pain medication and there were concerns that she was misusing over the counter medication. Rebecca denied any current drug misuse.

Nick (41), Rebecca's new partner, also had a long term drug use history and had spent several years incarcerated due to his drug misuse. Nick had a long history of childhood trauma involving sexual abuse by a family friend. Nick and Rebecca had known each other for many years before their relationship started about 9 months ago. There were no current reports about domestic violence and Rebecca stated that Nick had never been violent towards her. Nick also reported using a small amount of cannabis to help him sleep at night and because of anxiety. Nick denied any current drug misuse.

Nick was on opioid treatment at the same clinic as Rebecca and was on buprenorphine. The clinic had no concerns with either Nick or Rebecca's participation in treatment and told FaCS they were both progressing positively.

Teachers at the school believed that the children were significantly traumatised by their experiences of domestic violence and ongoing issues of parental drug misuse. Rebecca appeared easily frustrated and aggressive when they spoke to her and she did not respond to the kids' needs. The school was also worried about Nick because of his criminal history.

Keisha was often without her lunch and other school supplies. She was reluctant to talk to teachers and was teary at school. There were reports that Keisha did a lot of caring for Luke and Kane and concern about a possible sexual assault by a family friend. Luke was diagnosed with ADHD but was inconsistent in taking his medication, stating he either forgot or didn't have any left. He was impulsive and aggressive with other kids and the school found his behaviour difficult to manage. Kane attended the local pre school 3 days a week. He often presented dirty, very quiet and passive and the pre-school reported concerns about his development.

FaCS case workers found Rebecca difficult to engage and they were very worried she was still misusing drugs because of her aggressive and agitated behaviour. Due to ongoing concerns for the children, and the conflicting information from the AOD treatment provider and the school, the case worker requested the Clinical Issues Team (CIT) participate in a group supervision session about the family. Group supervision allows case workers to discuss cases and reflect on practice. Group members talk through, scrutinise and challenge thinking and decisions.

The CIT consultant encouraged the case worker to invite the opioid treatment provider and the school to group supervision together. The case worker was nervous about asking clinic staff to attend group supervision because she'd been told in the past that the AOD service and FaCS didn't work together. The case worker was also worried she lacked knowledge about AOD use and opioid treatment and thought this may create issues communicating with the family.

A group supervision session was held the following week with the child protection team, health professionals from the AOD service, the children's teachers, school principal and the CIT consultant. The health professionals provided useful information to the school and FaCS about the parents' opioid treatment and journey of recovery from AOD dependence. The school acknowledged they could try to engage with Rebecca and Nick more openly and sensitively, as they stated they had been fearful because of their aggressive behaviour and criminal history. The AOD service also acknowledged they had limited discussion about the children with Nick and Rebecca and needed to do more.

This discussion facilitated the development of a coordinated plan to support the whole family. A subsequent case plan meeting was held with the parents, the school, opioid treatment provider and other services involved. Nick and Rebecca engaged well in the meeting as they felt better understood and supported. Nick even met with the school principal and talked to him about his life story and own experiences of childhood trauma. The principal later advised the case worker that "he never really thought about Nick's personal story and he understood more now about his past drug use and time in prison". This demonstrates the importance of thoughtful communication and collaboration, as this promotes better outcomes for both the parents and the children.

"Effective interventions require much more than a good heart and a commitment to children's welfare. It is exceptionally complex work that requires talented practitioners who have high level interpersonal skills and the requisite knowledge and support"

(Lonne et al. 2010).

Practice Point

Do you know if your local Community Services Centre is a Practice First site?

Have you ever attended a group supervision meeting to discuss the concerns and future plans for one of your clients?

3.2.3 PRACTICE FIRST

In recognition of the need for better, long lasting outcomes for children and their families, FaCS has been changing the way it works with children and families and other services providers. One example of this change in practice has been through the development of Practice First as a model for child protection service delivery. Its focus is on changing the practice culture across the spectrum of work with families – assessment, intervention and collaboration with partner agencies. Practice First aims to achieve safety for children and families through skilful child protection practice, shared management of risk and genuine relationships with families and community. Practice First values collaboration with families, community, government and the non-government sector.

The 10 guiding principles of Practice First are:

1. ethics and values are integral to good practice
2. families have a right to respect
3. an appreciation of context strengthens practice
4. language impacts on practice
5. good practice is built on both knowledge and skills
6. practitioners do best in a culture that fosters learning, hope and curiosity
7. reflection leads to better outcomes
8. sharing risk leads to better decision making
9. the quality of the relationship makes a significant impact on effectiveness
10. relationships have a cascade effect.

The key focus of the Practice First approach includes:

1. Greater collaboration

Group Supervision is at the heart of Practice First. Caseworkers, managers, casework specialists, psychologists and other specialist staff such as the Clinical Issues team consultants meet each week to discuss cases and reflect on practice. Group members talk through, scrutinise and challenge thinking and decisions. Group Supervision also helps staff manage any emotional response to their challenging work, by creating the space to share their worries and hopes about their work with families. Caseworkers can draw on multiple viewpoints, research and practice expertise to support their practice – saving time and sharing the risk.

Partner agencies are regularly invited to Group Supervision sessions, which can include local AOD services. This genuine partnership has many benefits: it creates more efficient and effective referrals and information sharing, shared understanding of the risks and protective factors, greater transparency around decisions, more purposeful case plans and wrap-around services, and ultimately, better outcomes for children and families.

2. Better communication

Greater communication with partner agencies helps FaCS create a clearer picture about a child's safety and their family's situation. Practice First encourages FaCS to seek feedback from partner agencies on its work and areas for improvement. Regular communication also creates opportunities for innovative and responsive support for families, tailored specifically to their needs.

3. More time with families

Practice First encourages practitioners to spend more time with families. This could be taking them to appointments or joining in family activities that lead to stronger safety assessments and genuine relationships that support change. For example, caseworkers are being supported to use motivational interviewing strategies with women with substance use problems to engage and support them in making good decisions for themselves and their children. FaCS can invite partner agencies to do joint home visits or engage in family activities more regularly to work together to build trust and to support clients.

4. Determined effort to keep families together

Practice First requires practitioners to explore all avenues to keep a family together, where it is safe to do so. This means collaboration with, and relying on the expertise of partners to support families through change and to create safe homes for children and young people.

For AOD workers involved with women and their children, the implications of the Practice Standards and the Practice First initiative should be that there is an improvement in the collaborative nature of the relationship between services.

3.3 Structure of FaCS in NSW

The FaCS child protection workforce consists of around 2,000 people, most of whom work directly with clients. They have a range of skills, qualifications and experience that they bring to frontline roles.

The FaCS offices located throughout NSW are referred to as Community Service Centres (CSC). There are currently over 80 CSCs across seven regions of NSW. For a map of the regions see:

www.facs.nsw.gov.au/__data/assets/file/0005/273965/local_facs_districts_a3.pdf

For contact details for each of the CSCs go to:

www.community.nsw.gov.au/docs_menu/about_us/contact_us/community_services_centres.html

3.3.1 FACS PERSONNEL

Managers Client Services (MCS)

The MCS is the practice leader of the CSC. Their role is to support and enable practice. They support the Managers Casework in further skill development and have overall responsibility for the office.

Managers Casework (MCW)

The MCW is the lead practitioner for their team. They focus on the team's practice skills, take responsibility for casework, and model and lead their team to good outcomes.

Caseworkers (CW)

CWs are the frontline workers. The primary role of a CW is to work directly with families. CWs work as a part of a team. CWs largely come from a social work background or other tertiary studies such as psychology. CWs must have a university undergraduate degree as a minimum qualification.

Aboriginal staff

Community Services employ a range of Aboriginal staff across the organisation. FaCS has a commitment to ensure that service delivery and decision making is informed by Aboriginal participation at at all levels. Aboriginal consultation should continue throughout Community Services' involvement in the life of an Aboriginal child or young person. Staff have access to a range of internal formal and informal consultation mechanisms. FaCS has an Aboriginal Consultation Guide which provides clear and easily accessible advice about the consultation required when making decisions about Aboriginal children.

For a copy of the FaCS Aboriginal Consultation Guide:

www.community.nsw.gov.au/__data/assets/pdf_file/0019/322228/aboriginal_consultation_guide.pdf

Multicultural staff

FaCS employs a range of staff from Culturally and Linguistic Diverse (CALD) backgrounds. Some are employed in designated multicultural positions to work with specific communities and others are generalist workers. FaCS caseworkers are encouraged to consult with these workers and/or the Multicultural Services Unit to support culturally appropriate ways of working with families from CALD communities.

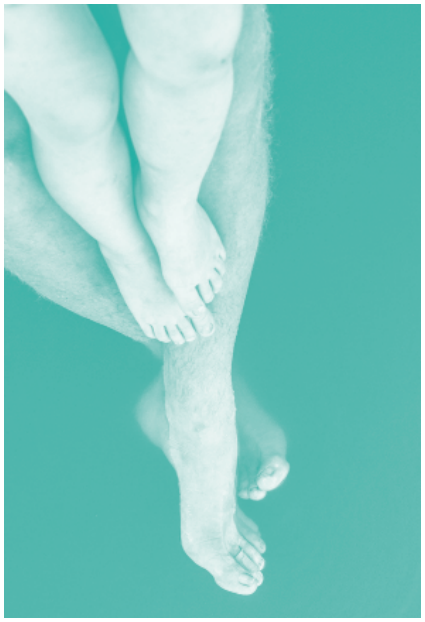
Casework Specialists (CWS)

The CWSs have a critical role in practice support to the CWs. CWS support the CWs in group supervision by offering a different perspective on how the presenting case is viewed, and by modelling and maintaining a position of openness, curiosity and critical reflection.

CWS focus on linking the standards to practice and supporting the team by providing relevant policy, procedure and research to support casework considerations and decision making. They may be allocated tasks from the group supervision session to assist in the progression of casework activity, practice and quality assurance work. Their role is to support, coach and model casework practice and development. They do this by assisting the team in transferring theory and knowledge into practice and skills.

"Strengthening protective factors has been shown to be an effective intervention strategy for working with vulnerable families"

(Child Family Community Australia, 2013).



Psychologists

The role of the psychologist is to work closely with the CWS to support and strengthen practice as well as provide consultation, assessments and interventions. Psychologists are allocated to teams. They provide research and practice advice as required and may be allocated tasks from the group supervision session to assist in the progression of case planning. Psychologists also carry out assessment with children and parents involved with FaCS, including parenting capacity and attachment.

Legal Officers

Wherever possible, Legal Officers attend group supervision meetings when a case being discussed is before the Children's Court, or where there is a possibility that it may end up in court. They provide advice in the meeting as needed. Attendance at these meeting gives Legal Officers opportunities to view families differently and enables them to bring a greater child focus to the court process.

(Source: Family and Community Services, 2014; pp 30-34)

3.4 Child Protection Processes within FaCS

3.4.1 RISK ASSESSMENT FUNCTIONS

Section 30 of the Children and Young Persons (Care and Protection) Act 1998 identifies FaCS as the agency responsible for the assessment of reports that a child or young person is suspected of being at risk of significant harm. This involves a two-tiered risk assessment approach:

1. Initial assessment – undertaken by FaCS Helpline CWs. This is a process to screen and prioritise reports and requests for assistance, so that the most appropriate response to the information is made.
2. Secondary assessment – undertaken by FaCS CWs at the local CSC. This is a process that leads to a professional opinion about safety, risk and harm, and informs decisions about a child or young person's need for care and protection.

3.4.2 ASSESSING RISK OF SIGNIFICANT HARM TO CHILDREN

Assessing and reporting potential or actual significant risk of harm to children is challenging for AOD workers engaged with parents in treatment. It is vital that the best interests of children are at the core of any interactions with families.

The term 'risk of significant harm' (ROSH) is pivotal to the Children and Young Persons (Care and Protection) Act 1998. Risk in the child protection context refers to the relative likelihood of something occurring in the future.

Agencies and practitioners are required to make a judgement about whether the known facts or observations may constitute a risk of harm to a child or young person from abuse or neglect. In general, it is clear that a sound judgement will require consideration of the likely degree of harm taking into account the following factors:

- the age, development, functioning and vulnerability of the child or young person
- the behaviour of a child or young person that suggests they may have been, or are being, harmed by another person
- history of previous harm
- behaviour by another person, that has had, or is having, a demonstrated negative impact on the healthy development, safety, welfare and wellbeing of the child or young person (e.g. AOD use issues, domestic violence or mental health issues)
- contextual risk factors (eg: recent abuse or neglect of a sibling, or a parent recently experiencing significant problems in managing a child or young person's behaviour)
- indications that a child or a young

person's emotional, physical or psychological wellbeing is significantly affected as a result of abuse and neglect.

3.4.3 MAKING A REPORT OF CHILD RISK

AOD workers involved with parents of dependent children are required by legislation and also by their agencies policies and procedure to determine if a child or young person is at risk of significant harm and to then respond appropriately according to the drections in the Mandatory Reporter Guidelines (MRG).

The MRG is an interactive and online guide which assists front-line mandatory reporters such as police officers, teachers, nurses, social workers, and NGO staff to determine whether a case meets the risk of significant harm threshold for reporting children and young people at risk in NSW.

The MRG can assist decision making so that AOD workers do not have to make decisions in isolation but are supported by evidence and child protection practice wisdom of what is more likely to constitute ROSH.

Child protection concerns can be made directly to the Child Protection Helpline, however, the report should always be informed by the MRG, which defines the reporting threshold for statutory child protection reports.

The Child Protection Helpline is contactable on 133 627 and is available 24 hours a day, 7 days a week.

Reporting by telephone is recommended where:

- the child may require an immediate response due to the currency of evidence that would establish abuse or harm
- the child or young person has a critical need for immediate intervention – for example, a child is currently alone, without supervision or is homeless
- the alleged person causing harm has access to the child and there is concern that the child may experience harm in the foreseeable future
- there is a complexity to the information (for example, substantial history of abuse or detailed information about the child or family) which is more easily communicated verbally than in writing
- the reporter is unsure about how to interpret the indicators of abuse and/or neglect, and may need to 'talk through' the information with a Helpline CW.

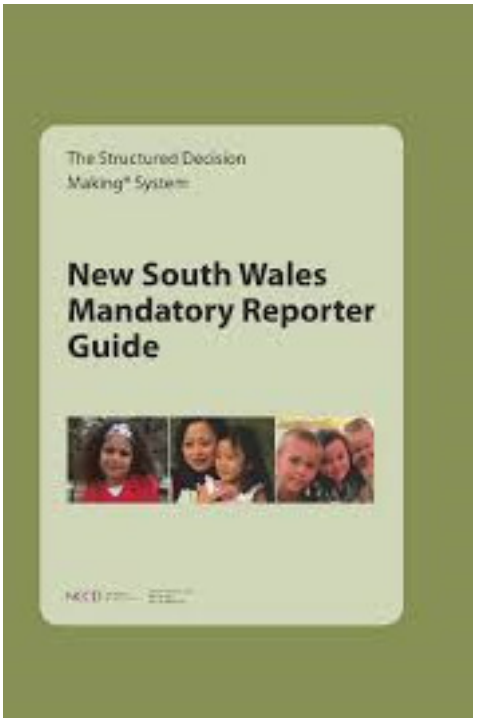
Helpline eReporting is now available for mandatory reporters to make child protection reports to FaCS. eReports are delivered securely and automatically to the Child Protection Helpline for assessment. eReporting is easily accessible and simple to use. Helpline eReporting must only be used for non-imminent, suspected risk of significant harm reports. All urgent matters must still be made by telephone to the Child Protection Helpline.

eReporting is available at:

https://kidsreport.facs.nsw.gov.au

To access the online MRG tool to assist with determining the level of risk and the process for reporting see:

http://www.keepthemsafe.nsw.gov.au/v1/online_mandatory_reporter_guide



"Mandatory reporting has been found to increase public awareness of child abuse..."

(Higgins, et al. 2009) .

Practice Point

Are you aware of the limits of confidentiality in regards to child protection?

Do your clients understand the concept of "mandatory reporting"?

Are you confident when explaining the limits of confidentiality to clients in regards to child protection?

Should I inform the family of a report?

It is good practice to discuss concerns with the parent or carer and to advise them of your legal or professional obligations to report your concerns to Community Services.

This is especially the case for mandatory reporters who have an ongoing relationship with the parent, such as family support services, AOD services, counsellors or health care professionals.

The decision to inform the family of a report should be guided by professional judgment and the principles of working in partnership with families and involving children and young people in decisions that affect them.

Practitioners can prepare for this by dealing with the issue of mandatory reporting obligations early in the relationship between the parent and the service/agency.

However, there may be circumstances because of the urgency of the situation or the perceived risk to the safety of the child or even to the reporter themselves, where the matter is reported prior to telling the parent or without informing the parent/carer.

(Source: Child Wellbeing and Child Protection – NSW Interagency Guidelines, 2012)

Safeguards for reporters

Reports to FaCS are confidential and the reporter's identity (if known) is protected by law if the report is made in good faith. The law offers the following protections:

- the report shall not be held to be a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct
- no liability for defamation can be incurred because of the making of the report. The report, or its contents, is not admissible in any proceedings as evidence against the person who made the report
- a person cannot be compelled by a court to provide the report or give any evidence as to its contents
- a report is an exempt document under the Freedom of Information Act 1989.

If law enforcement agencies require the identity of a reporter in order to investigate serious offences alleged to have been committed against children or young people, the identity of the reporter may be released to the police.

This provision was effective from the end of January 2010. It aims for a balance between the privacy of the reporter and the safety of the child or young person. The reporter will be notified that their identity is to be released to the police unless doing this would prejudice the investigation.

Feedback to reporters

The Child Protection Helpline will provide feedback by letter or fax to mandatory reporters on the reports it receives. If the feedback indicates that the statutory threshold is not met, mandatory reporters may need to consider what additional services or supports could be provided locally. Services offered should assist in addressing identified problems and minimising the risk of future harm.

Under Sections 248 and 254 of the Children and Young Persons (Care nd Protection) Act 1998, feedback can be provided to mandatory reporters where this disclosure is for the purpose of furthering the safety, welfare and wellbeing of a child or young person.

When a report is made, the Helpline will inform the reporter about the initial action to be taken. Mandatory reporters, except NSW Police, will be advised in writing either that the report has been closed at the Helpline or transferred to a CSC or a JIRT. Feedback will include details of which CSC or JIRT the matter has been referred to. NSW Police are provided with an automatic receipt of their report, providing a reference number.

www.community.nsw.gov.au/kts/guidelines/documents/reporting_section.pdf

3.4.4 PROCESSES FOLLOWING A REPORT TO FACS

The flowchart to which you can link below provides an overview of the process following a report to FaCS. The flowchart includes links to further explanations regarding the services/roles within the process.

Responding to a Child Wellbeing concern or Child Protection Report Flowchart:

www.community.nsw.gov.au/__data/assets/pdf_file/0009/336294/responding_flowchart.pdf

Safety and Risk assessment (SARA)

When a report is assessed by the Child Protection Helpline that further action is required, it will be forwarded to a CSC or a JIRT for possible further investigation and assessment, which may include a field response.

A suite of structured decision making tools (SDM) known as SARA, are used by FaCS CWs. SARA tools include the Safety Assessment, Risk Assessment and Risk Reassessment. The purpose of the SARA tools is to assist CWs in assessing safety and risk issues for the children, young people and families they visit. There are three components to the SARA tool that CWs complete at specific periods in time for a family: a safety assessment, risk assessment and risk re-assessment.

- Safety Assessment – The SDM Safety Assessment helps assess whether any child or young person is likely to be in immediate danger of significant harm and determines what interventions should be put in place to provide immediate appropriate protection
- Risk Assessment – The SDM Risk Assessment helps to identify whether parents have a very high, high, moderate or low probability of abusing or neglecting their child/children in the future. The Risk Assessment is actuarially based; that is, all elements have been validated after analysis of case outcomes from a large sample of child protection reports.
- Risk Reassessment – The Risk Reassessment is used periodically to evaluate potential changes in a family's risk level and includes assessment of the family's progress towards case plan goals.

For further information:
www.community.nsw.gov.au/__data/assets/pdf_file/0006/336318/investigation_assessment.pdf

3.4.5 SAFETY PLANNING

Another component of SARA is the development of safety plans with families. A safety plan is a written, mutually developed, arrangement between the child protection CW and the family.

A safety plan is used in situations where the safety assessment decision is safe with plan. By engaging and interacting with the family, a safety plan can be developed with them to clearly set out the interventions in place and follow-up actions to mitigate dangers so that children can remain in the home, at least for the present time.

Safety plans with families address:

- What is the danger?
- What will be done?
- Who will do it and by when?
- Who will check?
- Monitoring the safety plan
- Adjusting or modifying safety interventions.

Positive feedback from parents includes: "this is the first time ever since working with FaCS that I understand what I need to do"
(a mum talking about safety planning who has been involved with FaCS for many years)

Positive feedback from staff includes: "Most helpful to me was the advice about trying to get the family to identify the dangers themselves, and trying to find ways to word what the danger is, in language that the family understands" (FaCS CW)

The Clinical Issues Team provide

Parenting capacity refers to "the ability of parents or caregivers to ensure that the child's developmental needs are being appropriately and adequately responded to, and to be able to adapt to the child's changing needs over time."

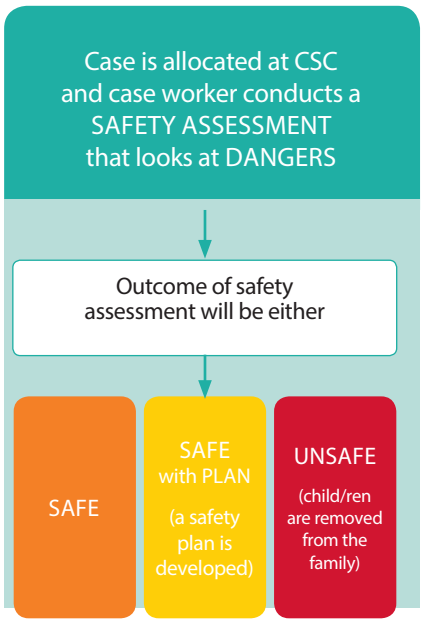
(UK Department of Health, Department for Education and Employment, and Home Office, 2000).

training for CSC staff in developing safety plans where there are AOD, mental health and/or domestic violence concerns. Some CSCs also invite local NGOs with whom they work to attend this training.

For further information regarding Safety Planning and the Safety Planning Resource, contact the Clinical Issues Team within the OSP, FaCS

clinical.issues@facs.nsw.gov.au

Figure 2. Safety assessment



Source: Clinical Issues Team, OSP, FaCS

Practice Point

Have you been included as part of a safety plan with families you are working with by the local CSC?

Consider what role you or your service could play in supporting the development of good safety plans in collaboration with FaCS.

Joint Investigation Response Teams

(JIRTs) are made up of FaCS, NSW Police and NSW Ministry of Health professionals who undertake joint investigation of child protection matters.

Joint investigations link the risk assessment and protective interventions of FaCS with the criminal investigation conducted by police.

FaCS and NSW Police have an equal partnership and share responsibility for the operation of JIRTs. The FaCS component of JIRT operates from 23 sites. FaCS is co-located with Police at 11 sites, there are six non co-located sites and there are six JIRT trained staff attached to regional/remote locations.

NSW Ministry of Health provides medical examination, counselling and therapeutic services to children or young people and their parents or carers, when required.

By working together as a JIRT, FaCS, Police and Health professionals provide a more effective investigative process and better understand each agency's role so the best outcome for the child or young person is achieved.

3.4.6 ASSESSMENT OF PARENTING CAPACITY

A critical factor in relation to child risk and protection involves the extent to which a parent is considered capable of parenting in the present and the future. AOD services need to have at least an understanding of the concept of parenting capacity, how it is assessed by child protection services and may even undertake parenting capacity assessments within their service.

Competent parenting is about the ability to change, depending on the requirements and circumstances of the child. Adaptability is related to three underpinning concepts:

1. perceptiveness – a parent's awarenessof their child and what is happening around them and the effects on a child
2. responsiveness – the extent to which a parent connects with their child
3. flexibility – the ability of a parent to respond in different ways according

to the needs or demands of specific situations.

The concept of the 'good enough' parent needs to be considered when discussing parenting capacity. Good enough parenting is used to describe the minimum amount of care needed so as not to cause harm to a child.

It is the quality of the immediate behaviour of the parent towards their child that is the major influence on the child's wellbeing. However, there are inconsistent standards as to what constitutes acceptable parental behaviour and how to quantify minimum parenting standards.

(Source: Parenting capacity assessment - improving decision making, DoCS, 2006)

Assessment of a parent's capacity to care for their child is a complex process, requiring critical thought and analysis of an individual situation. As White (2005, p. 3) states, "there is some debate as to whether comprehensive parenting capacity assessments are in fact possible". Factors such as current and ongoing AOD use issues and mental illness are integral to any parental capacity assessment. AOD workers who have engaged with a parent in treatment are often in a prime position to provide input into parenting capacity assessments. However, AOD workers need to be mindful of the risk of minimising concerns about a parent's capacity with the hope of maintaining the relationship with the parent (WA Department for Child Protection, 2011).

When making assessments of parents living with complex issues, such as AOD use issues and mental health problems, assessments need to determine how such problems affect parental capacity. The presence of a diagnosis is not sufficient to determine risk. "Assessing parent-child interactions, the quality of the home environment, the parent's perception of child behaviour, the parent's social support networks and his or her ability to solve problems is more important for determining whether a child is at risk of abuse and neglect then simply identifying or diagnosing parental problems such as substance abuse" (Bromfield et al., 2010; p. 14).

Guidelines for FaCS CWs when assessing parental capacity include:

- use of multiple sources of information including parents, children, observations, information from other relevant parties or services
- avoiding over-reliance on instruments such as psychological tools that can vary in their reliability
- recognition of the issue of 'faking good'. That is, a parent may present themselves in a positive light when being observed or responding to subjective assessment tools
- readiness for change
- collaborative practice
- worker judgements regarding appropriate parenting standards. Practitioners need to examine the values that underlie their assessments
- supervision and training on parenting and assessment approaches
- using research findings. Child protection workers are urged to be informed about the latest research and evidence-based practice
- awareness of the impact of cultural and other diversity on parenting capacity assessment
- tailoring parenting capacity assessment for parents with specific needs.

(NSW DoCS, 2006b)

For a review of the literature on the assessment of parenting capacity:

www.community.nsw.gov.au/__data/assets/pdf_file/0020/321635/research_parenting_capacity.pdf

Implications for AOD Workers

AOD workers are unlikely to be required to undertake a parenting capacity assessment. However, a FaCS CW may ask for input from AOD services involved with a parent in order to complete a parenting capacity assessment.

3.4.7 USE OF POWERS TO REMOVE A CHILD OR YOUNG PERSON

Removing a child or young person from their parents or caregivers, or assuming care responsibility for them, is an extremely intrusive action and is only considered where:

- there are reasonable grounds to believe that a child is at risk of serious harm and the risk is immediate
- less intrusive actions have been considered and excluded due to their not being sufficient to adequately address issues of safety, welfare and wellbeing
- there is evidence that can be put before the Children's Court that the child or young person is in need of care and protection.

Where there is an immediate risk of serious harm to a child or young person and it is not possible to secure the agreement of a parent or caregiver to make safe arrangements for their care, emergency action may be required under the powers of the Children and Young Persons (Care and Protection) Act 1998.

Below is an example of a safety plan that could be developed with the family to help children remain safely within the home:

Safety Plan for Sue and David Bloggs

What is the danger?

The CP service has received information that Sue and David are misusing drugs and this use is preventing them from taking care of Hannah and providing for her needs.

The CP service and the Early Childhood Nurse (ECN) Mary Brown are concerned that parents Sue and David are not regularly taking baby Hannah (3 months) to the ECN for her health check.

The CP service and the ECN Mary Brown are concerned that baby Hannah is under weight and is very lethargic.

What will be done?

Caseworker (insert name) and Mary Brown will visit the home to undertake a health check for Hannah tomorrow at 9:00am.

Leanne Graber (aunt) will come to the house each day and assist with Hannah after she takes her own children to school starting from tomorrow morning.

Leanne will be at the house at 9:30 and will go shopping with Sue and David to purchase formula, nappies etc to meet Hannah's needs.

Caseworker (insert name) will conduct another home visit in 3 days time on (insert date, time) to further discuss with Sue and David what is getting in the way of their care of Hannah.

ECN Mary Brown will also visit the family at home over the next 7 days.

Starting today, if Sue and David decide to use drugs they will arrange overnight care of Hannah with either Leanne or grandmother Veronica Anderson.

Sue, David and Hannah will stay with Leanne over the weekend. If they decide to use drugs they will leave Leanne's house and leave Hannah with Leanne.

Who will do it and by when?

Sue and David will ensure they are home at the planned time to see the ECN Mary Brown and the caseworker (insert name) tomorrow (Insert date) at 9:00 and on (insert date, time of other planned visits).

Sue and David will accept assistance from Leanne Graber on a daily basis. Leanne will visit the family every day for 5 school days. (Leanne's phone number: XXXX)

Caseworker (insert name) and ECN Mary Brown will each conduct 2 home visits this week. One joint (tomorrow) and one each separately.

Leanne or Veronica Anderson will look after Hannah overnight if Sue or David request it (Veronica's phone number: XXXX)

Leanne will have the family to stay over the weekend from Friday evening at 6pm to Sunday night.

Who will check?

Caseworker will check that Sue and David have purchased formula, nappies etc to meet Hannah's needs.

ECN Mary Brown will call the caseworker (insert name) if she has further concerns.

Leanne will check in with the parents daily and will contact the caseworker if required.

Caseworker (insert name) will check in with Veronica Anderson next week

Source: Safety Planning Resource, FaCS 2014

Permanency planning is defined as "a case planning process aimed at securing stability and continuity for children in out-of-home care"

(Tilbury and Osmond in Roth, 2013)

3.5 Out of Home Care

The NSW out-of-home care (OOHC) contracted care program is a partnership between participating funded agencies and FaCS. In 2012-13 there were 50, 307 children in some form of OOHC. 43% of those in OOHC were in foster care, 48% were living with relatives/kin and more than 5% were in residential care (AIHW, 2014).

LEGAL REGULATIONS OF OOHC

OOHC is provided under the Children and Young Persons (Care and Protection) Act 1998 and the Children and Young Persons (Care and Protection) Regulation 2012. The Adoption Act 2000 governs the process for the making of adoption orders.

The Child Protection (Working with Children) Act 2012 and the Child Protection (Working with Children) Regulation 2013, administered by the Office of the Children's Guardian, determines the requirements for people defined in child-related work, including OOHC service providers.

For further information regarding the guidelines for OOHC:

www.community.nsw.gov.au/__data/assets/pdf_file/0015/320910/oohc_contracted_care_program_guidelines.pdf

3.6 Permanency Planning

The concept of permanency planning emerged in the 1970s, first in the US and later in the UK. The impetus for the permanency movement was in response to concerns about children in OOHC being caught in a "revolving door" of placements with significant impacts on health, education and wellbeing. Permanency planning is defined as "a case planning process aimed at securing stability and continuity for children in OOHC" (Tilbury and Osmond in Roth, 2013).

There have been significant reforms in NSW over the past few years in regards to the placement and movement of children involved with OOHC. Permanency planning provisions were introduced in NSW in 2001.

In November 2008, the NSW Parliament passed an Adoption Amendment to the NSW Adoption Act 2000. The implication is that a foster carer who has cared for a child for two years or more is now able to apply to the Supreme Court to adopt the child. Importantly, the court has the power to approve an application against the wishes of the child's parents. A surname change to that of the adoptive parents can also be approved by the court against the wishes of the birth parents.

For further information regarding permanency planning refer to the Family Inclusion Network:

www.fin-nsw.org.au/main/page_advice_leaflets.html

Permanency planning is a requirement of the Children and Young Persons (Care and Protection) Act 1998. Recently there has been a significant amendment to the Act in relation to permanency placement. The Child Protection Legislation Amendment Bill 2014 has particular implications for the processes regarding permanency planning and placement.

The object of the Amendment Bill is:

- the recognition that the primary means of providing for the safety, welfare and wellbeing of children and young persons is by providing them with long-term, safe, nurturing, stable and secure environments through permanent placement in accordance with the permanent placement principles.

It recognises that every child and young person should have a permanent and stable home where possible, preferably with his or her birth family, and that unnecessary changes to care arrangements create instability and uncertainty for a child or young person. Permanency planning involves giving early consideration to the long-term needs of a child being placed in OOHC, based on a thorough assessment of family strengths, to determine whether or not there is a realistic possibility of restoration of the child to the parent/s.

Permanency planning can include:

- restoration to the birth family
- long-term authorised foster care (including sole parental responsibility orders)
- relative and kinship placement adoption.

When considering a care plan, the Children's Court will pay particular attention to aspects of permanency planning. The Children's Court cannot make final care Orders unless it finds that permanency planning has been appropriately addressed. In the case of a child or young person not presently living with their family, it will consider whether there is a realistic possibility of the child or young person returning to their family, or whether the child or young person should remain in an alternative placement long term.

For a copy of FaCS Permanency Planning Guidelines:

www.community.nsw.gov.au/__data/assets/pdf_file/0019/322246/permplan_guidelines.pdf

"Drug-testing should not be seen as the endpoint, rather it is best seen as trying to achieve long-term benefits through referral to treatment"

(Wood et al., 2006).

3.7 Restoration Planning

In circumstances, such as at the end of temporary care arrangements, where the case plan goal is restoration of a child or young person to their parent or caregiver, attention must be given to coordinated restoration planning and support. This includes organising support services for parents to improve parenting capacity and establishing clear goals for the parents as to what they need to achieve for restoration to occur.

Some of the main considerations following the return of the child or young person to their parent's care include:

- tailoring support services to reduce the likelihood of further need for placement once the child or young person is reunified to the parents' care
- having contingency plans in place such as providing parents, children and young people with emergency numbers and access to a safe adult if assistance is required
- reassuring family members that asking for help does not imply that the child or young person will be removed.

In situations where restoration is the case plan goal for the family, a case meeting will be held with all of the relevant agencies and the family to clearly outline the case plan goal, objectives and tasks, and to give clear timeframes for both the parents and the relevant agencies. It is important for the support services to understand the role of each group in working with the family.

The case review prior to the child returning home should consider information from each of the participants, which covers:

- the progress and achievements made towards meeting the case plan objectives and tasks
- any lack of progress on tasks that would lead to ongoing concerns for the safety, welfare and wellbeing of the child
- the progress of the contact visits and the relationship between the parents and the child
- preparing the child for their return home
- the foster/relative carers' role in supporting the child during the restoration process
- the ongoing support needs of the child and family after restoration
- how the support needs will be met and for how long. If there is an ongoing Order after restoration, what support role is to be taken by each agency.

Practice Point

Has your service been involved in the restoration planning process?

Consider what the implications of a restoration plan may be for a parent's ongoing involvement with your service.

3.8 Parental Drug Testing Policy

Drug testing of parents involved with FaCS is used to assist in cases of children being removed or in situations involving restoration of a child where serious and persistent drug use is suspected. According to the FaCS Parental Drug Testing Policy (2009), there are three main scenarios in which testing is considered to be appropriate:

1. Prior to removal – where serious and persistent drug use is considered to be at least one of the reasons for a child's current risk of harm and this cannot be confirmed by other means, testing is part of a holistic assessment to establish whether removal of a child is warranted.
2. Prior to restoration (when testing is mandatory)
   a. Where a child has been in OOHC primarily due to the serious and persistent drug use of a parent and restoration is now being considered; OR
   b. Where drug use was not the primary concern in placement of the child in OOHC, but there are current concerns about possible serious and persistent drug use and restoration is being considered.
3. Following restoration – where a child has been restored, but a further risk of harm report has been made in which drug use is a concern.

The FaCS Parental Drug Testing Policy (2009) sets out the guidelines for drug testing as well as the consequences of positive tests and of failure to consent or comply with a testing regime. The policy also provides guidelines on treatment, waiting times and interaction with Children's Court timeframes and permanency planning.

For a copy of the Parental Drug Testing Policy:

www.community.nsw.gov.au/docswr/_assets/main/documents/drug_testing_policy%20.pdf

3.9 FaCS Case Meetings

A core component of case management with FaCS is the use of case meetings as a primary vehicle for developing individualised case plans for children and young people at risk of harm and their families. The term 'case meeting' is a generic one. Other terms have been, or are, used interchangeably – such as 'case planning meeting', 'case conference', 'case review meeting', 'interagency case meeting', or 'protection planning meeting'.

Case meetings are a tool to assist with case management, where more than one worker is involved, whether within or across organisations. They are an important part of the process and may be held at various points in the case management continuum, depending on the needs of the child, young person or family, urgency and complexity of the family's needs and changes in family circumstances.

Case meetings may be held to:

- define the roles and responsibilities of workers and organisations
- agree on the primary/key worker for the case
- define the purpose, intent, and direction of the intervention
- discuss an assessment
- develop a case plan
- progress a case plan
- make decisions
- review goals/actions
- plan towards case transfer and/or case closure.

Depending on the purpose, case meetings may or may not involve the child, young person and their family. However, the participation of the child, young person, family and other significant people should be promoted along with the participation of other relevant organisations and workers, if required. Stakeholders that are responsible for strategies in the case plan must participate.

Case meetings should:

- be chaired by the worker or organisation with case management responsibility (this may need to be negotiated between organisations)
- include the child, young person and their family, where appropriate
- represent the views of all stakeholders, including those who did not attend
- occur at regular intervals in line with monitoring of agreed actions
- have a clear agenda
- have clear meeting outcomes
- be documented, recorded and disseminated by the worker or organisation with lead case management responsibility within an agreed timeframe.

One of the main outcomes of a case meeting will be a case plan, based on collaborative action, and specifying the goals, objectives, tasks, timeframes and the persons responsible.
(Source: FaCS Interagency Guidelines, 2012)

Practice Point

When preparing for a case meeting with FaCS:

- Have you been informed of the purpose of the case meeting?
- Have you been informed as to who will be present at the case meeting?
- Have you clarified any expectations regarding your input into the case meeting?

Following a case meeting with FaCS:

- Have you received a copy of the record of recommendations following the case meeting?
- Are you clear about your service's involvement and responsibilities in regards to the case plan?
- Are you aware of the timeframe for reviewing the case plan?

"Collaboration is a mutually beneficial and well-defined relationship entered into by two or more organisations to achieve common goals. This relationship includes a commitment to mutual relationships and goals, a jointly developed structure and shared responsibility; mutual authority and accountability for success; and sharing of resources and rewards"

(Mattessich & Monsey in NSW Community Services, 2010b).

3.10 Troubleshooting Concerns about FaCS

FaCS personnel are bound by the FaCS Code of Ethical Conduct

For a copy of the FaCS code of Ethical Conduct:

http://www.facs.nsw.gov.au/__data/assets/file/0009/276750/FACS-Code-of-Ethical-Conduct.pdf

FaCS is usually not able to resolve complaints about decisions made by courts or tribunals. In these cases, FaCS may be able to provide information to assist, including suggested avenues to make a complaint.

Steps to making a complaint to FaCS:

1. In the first instance it is advisable to contact the MCW at the CSC concerned.
2. Wherever possible, complaints are best resolved informally by the people involved or their immediate supervisor. If not sure who to contact, ask to speak to the manager of the local CSC.
3. Call the FaCS Complaints Unit on 1800 000 164 to speak directly to a Complaints Officer available Monday to Friday 9am to 4.30pm.

   Or write to the FaCS Complaints Unit. For a proforma complaints letter click on this link:

   https://pra.community.nsw.gov.au/CSComplaints/. A letter of complaint can be faxed to 9716 2126.

   Alternatively a letter of complaint can be posted to:

   Reply Paid 63437
   Complaints Unit
   Community Services
   Locked Bag 4028
   Ashfield NSW 2131

   Email: complaints@community.nsw.gov.au
   Online: lodge your complaint online
4. If you are not happy with the outcome of your complaint, you have the right to take the complaint to another body for external review. Bodies that can undertake to review the matter include: NSW Ombudsman, Privacy NSW, Anti-Discrimination Board of NSW. The Administrative Decisions Tribunal can review certain decisions made by FaCS. Complaints can also be take to the Independent Commission Against Corruption.

   The complainant is responsible for:

   - providing a clear outline of the problem and the solution being sought
   - providing all relevant information available from the beginning of the process
   - letting FaCS know whether anyone else is currently dealing with the complaint
   - letting FaCS know of any new facts or if the complaint has been resolved
   - cooperating with FaCS respectfully.

   For a copy of the FaCS complaints process:

   www.community.nsw.gov.au/docs_menu/about_us/contact_us/complaints.html

4 SUPPORTING BETTER PARENTING

Parents entering into AOD treatment provides an opportunity for addressing and reducing the risk of harm to children.

A recently published NCETA report (Battams et al., 2010) into family sensitive practice in the AOD sector makes the following key recommendations in order for services to meet the needs of children and families:

- recognise the scope for preventative interventions
- be more responsive to the needs of parents and children
- be more cross-sectoral in approach
- enhance support to parents
- build on parent's coping strategies
- develop supportive relationships with children
- establish links with other services such as schools and child protection services.

It is also important that parenting programs assist in the healing of the parent-child relationship. As Bromfield and colleagues state, "witnessing or experiencing abuse and neglect in the family not only carries with it direct and indirect injuries to parents and children, but also undermines the parent-child relationships" (2010, p. 17).

A critical issue when supporting the healing of a parent-child relationship involves addressing issues around attachment. One successful program that specifically addresses attachment concerns is the Circle of Security. In essence, Circle of Security is a relationship-based, early intervention program designed to enhance attachment security between parents and children.

For further information regarding Circle of Security:

Circle of Security International – www.circleofsecurity.net

Early Childhood Australia – www.earlychildhoodaustralia.org.au

A further critical issue that commonly impacts on parents and parenting is the impact of domestic violence and the impact on previous trauma, both of which have a significant correlation with the AOD use issues, especially for women. Any parenting programs delivered need to acknowledge this context.

"Acknowledging the difficulties that parents may have coming to terms with their own experiences of trauma and victimisation and empathising with their situation does not mean ignoring or excusing abusive or neglectful behaviour directed towards their children. However, understanding parents' past histories may better enable practitioners to determine the underlying causes of parental problems, therefore helping them to engage parents and to assist them to make positive change" (Bromfield, et al., 2010; p. 14).

One model that has been developed that aims to address the needs of high-risk families with a complexity of needs is the Integrated Theoretical Framework. "The Integrated Theoretical Framework provides a model for assessing family functioning across multiple domains. In the course of doing so, the framework identifies immediate child protection issues and current family strengths" (Dawe and Harnett, 2014)

For a copy of the Integrated Theoretical Framework:

https://aifs.gov.au/cfca/2014/07/09/moving-beyond-a-simple-parent-training-model-of-intervention-use-of-the-integrated-theoretical-framework-in-child-protection

"Witnessing or experiencing abuse and neglect in the family not only carries with it direct and indirect injuries to parents and children, but also undermines the parent-child relationships"

(Bromfield et al. 2010, p. 17).

Practice Point

What do you know about local or statewide parenting services available in your area?

Does your agency have links with these parenting support services?

Is there information about these services available for distribution to clients in your service?

4.1 Parenting Programs and Initiatives

There are an increasing range of initiatives that have been funded to focus on the needs of families at risk. Research into effective components of parenting interventions have concluded that best practice involves programs that:

- encourage one-on-one learning
- focus on strengths rather than deficits
- offer a shared empowerment to families
- build strong client-practitioner relationships that are predictable and reliable
- develop positive expectations for change and heightened self-efficacy
- enhance problem-solving capacity
- provide information that is clear and concise
- praise parents wherever possible.

(Bromfield, et al., 2010).

For a review of the effectiveness of home visiting and other interventions with families affected by parental substance misuse, see Dawe, Harnett and Frye (2008). Improving outcomes for children living in families with parental substance misuse: What do we know and what should we do.

https://aifs.gov.au/cfca/publications/improving-outcomes-children-living-families-pare

FAMILY REFERRAL SERVICES (FRS)

FRS are delivered by NGOs under contract with NSW Kids and Families. Family Referral Services engage and assist vulnerable children, young people and families to access the support services they need to prevent escalation. FRS link families to a range of local support services including case management, housing, parenting education, supported play-groups, AOD mental health services, youth support services and respite care. FRS also have a role in improving the knowledge of service providers about local support services in their area, and strengthening coordination and collaboration.

For further information regarding FRS: www.familyreferralservice.com.au

EARLY INTERVENTION & PLACEMENT PREVENTION (EIPP)

The EIPP program provides appropriately targeted child, youth and family support services to reduce the likelihood of children and young people entering or remaining in the child protection and OOHC systems.

The EIPP is a voluntary, targeted program designed for families encountering problems that affect their ability to care for their children. The program identifies children and families who are vulnerable or likely to be at risk of harm, and provides them with targeted supports before further problems arise or become serious.

These services build upon direct-support services for children, youth and families provided by agencies previously funded under the Community Services Grant Program. During 2010/11 services funded under the Community Services Grants Program were transitioned into two streams. One stream, which focuses on services concerned with 'community strengthening' became part of the Community Builders program. The second stream, which focuses on the provision of services directly to children, young people and families, formed the basis of the EIPP.

A key component of the EIPP is that families can access the full range of services and supports they require through a single entry point, either through FaCS early intervention teams if there has been a report of risk or harm, or through the lead agency. This is intended to promote efficient and consistent service provision and a more collaborative approach to service delivery.

www.community.nsw.gov.au/__data/assets/pdf_file/0019/322282/early_inter_place_prevent_fund_program_guidelines.pdf

WHOLE FAMILY TEAMS (WFT)

WFTs have been established in Gosford, Newcastle, Nowra and Lismore. These teams provide specialist tertiary health services for families where there are AOD and mental health problems and child protection concerns. Referrals are primarily from CSCs, for families where there has been a substantiated Risk of Significant Harm Report (ROSH). Forty specialist clinical staff are currently employed under WFT funding and provide services to over 250 highly complex and vulnerable families per year, who require intensive coordinated care.

For further information on WFT refer to: www.keepthemsafe.nsw.gov.au/initiatives/acute_services/keep_them_safe_whole-family_teams

PARENTS UNDER PRESSURE (PUP)

PUP program was developed to address the multiple needs of high-risk families, that, if left unaddressed may impede their ability to protect and care for their children. The PUP program is a structured, manualised program designed to be delivered by trained staff over 12 sessions within the home setting. The PUP program addresses issues such as challenging the notion of an ideal parent, coping under pressure, building social support networks and effective communication in relationships.
Initial research into the effectiveness of the PUP program was conducted on 12 families also involved with pharmacotherapy clinics and showed high levels of satisfaction among those involved with PUP.
A randomised controlled trial of PUP found that involvement with the program led to significant decreases in a range of problem areas including substance use (Harnett, Dawe and Rendalls, 2004).

Further information about the PUP program is available at:
www.pupprogram.net.au

BRIGHTER FUTURES

Brighter Futures delivers targeted early intervention services to families with children under nine years of age, or families who are expecting a child, where the child/ren are at high risk of entering or escalating within the child protection system.

FaCS funds Brighter Futures non-government agencies across NSW to deliver a range of tailored interventions to high-risk children and families. It also funds the operation of the Brighter Futures Unit, which has a role in processing all non-risk of serious harm reports, community pathway referrals and provides lead agencies with child protection history for all referred clients.

All families referred to Brighter Futures must have a child under nine years of age, and at least one of the following five vulnerabilities:

1. domestic violence
2. AOD misuse
3. parental mental health issues
4. lack of parenting skills or inadequate supervision
5. parent(s) with significant learning difficulties or intellectual disability.

Further information on Brighter Futures is available at:

www.community.nsw.gov.au/__data/assets/pdf_file/0016/321037/bfu_fact_sheet_v4.pdf

ABORIGINAL CHILD AND FAMILY CENTRES

There are nine Aboriginal Child and Family Centres (ACFCs) in NSW which provide a mix of culturally safe services and supports for Aboriginal children aged 0–8 years and their families.

The types of services delivered through the centres include early childhood education and care, parent and family support, maternal and child health and adult education opportunities.

For copy of the guidelines for the Aboriginal Child and Family Centres:

http://www.community.nsw.gov.au/__data/assets/pdf_file/0016/321019/acfc_-program_guidelines_2014-15_2015.pdf

4.2 Key Parenting Resources

Children of Parents with a Mental Illness Website (COPMI)

The COPMI national initiative develops information for parents, their partners, carers, family and friends in support of children living in families with mental illness. This information complements online training courses developed by COPMI for professionals to support families either individually or through community services and programs.

www.copmi.net.au

Family Focus Project Toolkit

Eastern Drug and Alcohol Service (2010). Canberra, Department of Health and Ageing.

The Family Focus Toolkit is a collection of selected resources including screening tools, questionnaires, worksheets, and utility practice tools gathered from the sector, research and professional bodies.

http://nceta.flinders.edu.au/files/6513/0948/1146/EDAS_Family%20Focus%20Toolkit.pdf

For Kids' Sake: A Workforce Development Resource for Family Sensitive Policy and Practice in the Alcohol and Other Drugs Sector

Battams, S., A. M. Roche, A. Duvnjak, A. Trifonoff and P. Bywood (2010).Adelaide, NCETA. Flinders University.

This resource aims to minimise cases of child abuse or neglect by increasing collaboration between child and adult service agencies. It is an initiative developed by NCETA to improve the safety and welfare of children with parents who misuse AOD. The toolkit builds a bridge between AOD treatment and child protection sectors to improve cooperation and collaboration.

http://nceta.flinders.edu.au/files/3913/0915/8536/EN435%20Battams%20et%20al%202010%20.pdf

The signs of safety: Child protection practice framework (Western Australian Government 2011)

This policy document seeks to create a more constructive culture around child protection organisation and practice. Central to this is the use of specific practice tools and processes where professionals and family members can engage with each other in partnership to address situations of child abuse and maltreatment.

https://www.dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/SignsOfSafetyFramework2011.pdf

Stories from the field

Sandra's Story, by Tracy, Child Protection Caseworker, Department of Family and Community Services

Sandra wasn't surprised when we knocked on her door and said we were from FACS…My first impression as I watched Sandra and Lucas together was of a mum and bub in love. Sandra was calm and affectionate with Lucas, even with the stress of having us knocking on the door. My colleague and I explained to Sandra that we had received a report from the Child Protection Helpline and we needed to make sure she and Lucas were okay. The reporter told the helpline they had seen Lucas in his pram in the front yard alone at 2am. The reporter also said Sandra was growing cannabis in her backyard. It was a serious report given Lucas' age and the time of night. We needed to find out more… Sandra freely admitted to smoking pot socially but not around Lucas. She didn't think it was a problem or that it affected her ability to be a good mum. We assessed Lucas as safe but could see Sandra would benefit from some support during this difficult time in her life, so I began to see her once a week.

Lucas was just gorgeous and it was clear when I saw them together they had a close and loving bond. I have social work experience, but am new to FACS. I feel lucky to work at one of the original Practice First sites. I love the model and drew on lots of its techniques working with Sandra. I used motivational interviewing, which is a way of prompting discussion with a family about what changes they need to make in their lives. This helped Sandra see how reducing her cannabis use could create positive change in her life.

Many of Sandra's close friends smoked marijuana as well so it was a big part of her social life. We talked about the fact that she was a mum now – what kind of parent did she want to be for Lucas? What sort of home did she want to create as he grew into a boy and one day a man? Open-ended questions, affirmations and reflective listening worked really well with Sandra. We would talk about what life was like for Lucas now that Troy wasn't there. This helped us explore the positives for Lucas and Sandra could see how he benefitted when she wasn't afraid and stressed all the time. Reflective listening was particularly useful for me as a caseworker. I wanted to make sure I clearly understood what Sandra said and if I didn't understand, give her time to explain something to me in more detail. Before I left each home visit I would summarise what we'd discussed and the actions we each had to complete before the next time we met... Sandra saw we were there to help her and Lucas, not judge or split them apart.

Another great leap was when Sandra agreed to see a drug counsellor about her cannabis use. She had gone from minimising her drug use, to realising it wasn't ideal for Lucas, even if he was asleep. Through counselling, Sandra learnt her triggers for using drugs were stress and hanging out with a particular group of friends. She made the brave decision to end a number of her long-term friendships. This was a huge deal because some of these friends were more like a family and had helped Sandra during tough times. Sandra recognised this part of her life was over. She chose to put the needs of Lucas above her own. We were sitting among Lucas' toys one day and Sandra said to me, 'I'm all my son has now'. I think this was her light bulb moment. It showed me that her counselling and our work together had made her realise she had to change her life to be the best mum she could possibly be… During our time together I focused on being available to Sandra and never judging her... Sandra and I live in a pretty small town so we still run into each other at the shops sometimes – I love seeing her and Lucas, he is such a delight. She isn't scared of FACS anymore and she knows she can always call me if something comes up. Sandra has started a diploma in welfare so one day she can help other women break free from violence. I think she will do an incredible job.

Excerpt from FaCs (2014d). Shining a Light on Good Practice in NSW 2014.

5 INTERAGENCY COLLABORATION

Our capacity to relate to others is supported or undermined by the quality of our own support relationships (Johnston and Brinamen, 2005).

There is an ever-increasing call for more coordinated service responses for addressing the impact of parental AOD use on child wellbeing. Child protection, family services and health services such as AOD, need to work in partnership, with the needs of the children at the centre. There have been calls to move toward more integrated rather than separate services in order to minimise some of the challenges that are created when services work in isolation with differing focus (NSW Community Services, 2010).

A recent report into child protection processes nationally (The Allen Consulting Group, 2009) concluded that there is an urgent need to adopt a common approach within services most likely to come into regular contact with children and families (including health care workers, teachers, childcare workers and police). The common approach proposed has three consistent building blocks:

- mechanisms for identifying needs
- mechanisms to improve information sharing
- mechanisms to improve referral processes.

5.1 Challenges for Interagency Collaboration

Despite the fact that services and individual workers commonly have the best interest of families in mind, there are multiple factors that can impact on the extent to which services such as AOD and FaCS work in unison.

A study of AOD workers found that the top five 'most substantial' or 'very significant' barriers were:

- lack of access to resources and strategies
- limited mutual exchange of information
- competing priorities
- lack of education/training on child wellbeing/welfare issues
- lack of linkages between alcohol and other drugs and child/family welfare agencies.

(Trifonoff et al., 2009, in Battams et al., 2010).

Another commonly mentioned challenge involves the question of "who is the client?" Within AOD services, a therapeutic relationship is developed with an adult who may be a parent, whereas FaCS traditionally focuses on the child as the client. Balancing the rights and needs of children and parents at an interagency level can be challenging. "Urging AOD services to be more sensitive to clients' parenting roles and the needs of the children involved is not necessarily straightforward. At times the rights and needs of children, parents/clients and other family caregivers may be perceived to be in conflict. Adult-focused AOD services often take on an advocacy role for the parent in child protection situations. This may create inter-agency conflict and result in a reluctance to work collaboratively" (Battams et al., 2010; p. 3).

AOD services where parents are involved require the careful balancing of potentially conflicting needs. There is also a growing body of evidence that shows that engaging with parents and addressing their AOD use and parenting needs can have significant impacts on the wellbeing of dependent children (Battams et al., 2010; Dawe and Harnett, 2008).

Lack of understanding of processes and lack of transparency of decision making can lead to barriers between services. For example, recent reforms in legislation and changes in processes within FaCS have had impacts on AOD services that accommodate women with their children. Interviews of AOD workers (Jenner et al., 2014) found that, despite a limited number of services being available, there are an increasing number of women entering AOD treatment without their children in their care. As two AOD workers interviewed in the study indicated:

> For four years pretty consistently we have had children vacancies… we haven't been full (with children) because (FaCS) are removing children… We don't get children because they are either in permanent guardianship orders or the possibility of restoration looks very slim and they (women) are coming to us with the hope of restoration.
>
> We are the same. Sometimes we think "we're a child service and we don't have any children".

Lack of sharing of expertise between services can have significant implications for clients.

"The investment by governments and the non-government sector into family support and child protection services is significant, yet our separate efforts still fail many children and young people. We need a unified approach that recognises that the protection of children is not simply a matter for the statutory child protection systems. Families, communities, governments, business and services all have a role. And we need to work together"

(Council of Australian Government, 2009, p. 6).

The study by LeeJen (2014) highlighted the potential risk of FaCS CWs having limited knowledge and expertise in areas such as withdrawal effects of substances or the processes involved in addressing AOD use. For example, two AOD workers commented:

> (FaCS) will sometimes dictate treatment; they'll say "mum needs to come off methadone" which makes it really unsafe for her and her children… the methadone is actually a stabilising factor in their lives.
>
> We have had a few women who have been on prescribed Valium [in conjunction with pharmacotherapy] for however long…and it's like "bang, you need to be off it"… and we've had a couple of hairy situations where that's been the expectation and we've had to try to explain again the slow process that needs to occur.
>
> (LeeJen, 2014; p. 31-32)

Misunderstanding and poor communication around case planning, the expectations of the parent and the implications for AOD service providers can lead to frustration and conflict:

> They [FaCS] used to turn up with a 17-page care plan and now you never see one. Women have the impression if they do a residential program they will get their kids back and it's not the case today.
>
> Some [FaCS] workers will be engaged, will have a plan with our clients when she leaves us but … this is at an individual level, it is not system wide – we don't have an agreement with FaCS across the state although it'd be great to have that.
>
> If there was a collective approach [with FaCS] we could support them and the children instead of waiting until there is a crisis. That is a missed opportunity to work with the family… to work with children as well.
>
> (LeeJen, 2014)

Some of the factors which may impact upon interagency collaboration include:

- the stability of a sector and government (extent of reform and turnover in personnel)
- limited exchange of information
- competing priorities (treatment needs of adult client versus needs of the child)
- time spent on joint planning
- perceived stigma towards a service and clients involved with a service
- fears about the consequences of questions being raised about their children
- confidentiality practices
- potential for punitive rather than supportive approaches being taken by child protection services
- lack of common assessment processes
- resources for collaboration
- funding mechanisms
- different discourses and conceptual frameworks shaping perceptions of 'problems' and appropriate 'interventions'
- interagency and cross-government agreements
- joint accountability mechanisms
- professional and organisational culture.

(Battams and Roche, 2011; pp. 67-68).

5.1.1 RESOLVING DIFFERENCES BETWEEN AGENCIES

Effective collaboration requires all partners to be committed to working together and being open to challenges and feedback received from interagency partners. Managing conflict and resolving disputes is essential for family-focused practice.

Different perspectives and competing priorities will occur from time to time, for example:

- decisions in relation to a particular child or young person
- roles, professional and organisational philosophies, priorities and cultures
- systems issues
- status and real or perceived power issues
- communication
- level of commitment to the interagency approach and group dynamics
- attitudes and beliefs about families and community standards.

Where differences arise, these should be acknowledged and discussed as soon as possible so that each party can consider ways of resolving the issue that is in the best interests of the children or young persons concerned and that may inform more effective practices and procedures.

Where a fundamental difference is identified, an interagency review of the matter may be necessary. It is expected that all agencies will have clear policies and procedures on review and resolution of concerns raised by or in relation to agency partners.

Effective collaboration requires that resolution is reached and agencies work together in the best interests of children and young people.

Benefits of Interagency Practice

FOR CLIENTS	FOR WORKERS	FOR AGENCIES
A coordinated case plan can address a range of needs and provide more seamless service delivery	Sharing information, assessment knowledge and intervention responsibility is less stressful and more rewarding than acting individually	Reduces duplication of services and allows for greater efficiency in the utilisation of public resources
Cooperative efforts by agencies improves access to services	The quality of problem-solving and service planning is enhanced when all parties coordinate their efforts	Can assist in easing workforce limitations and barriers created by agency mandates
More diverse expertise is available due to the joined up resources of agencies	Increased contact and better relationships between service providers improves communication and role clarity, and eases the stress of individual work with clients in crisis	Improves the likelihood of meeting the varied and complex needs of clients
Models cooperation to clients, and exposes effective methods of problem-solving and relating to other professionals	Breaks down defensive ways of thinking, and reduces the undue responsibility or blame on any one worker or agency	Produces a wider picture of the needs of a community, and can lead to shared planning across a range of agencies

Source: NSW Department of Community Services, 2006C

5.2 Enhancing Interagency Collaboration

Working collaboratively is essential for the wellbeing of children and their parents. Connections and transparency between services may help to reduce situations where families with multiple and complex problems are referred from one service to another where little of no history of the family is known before their visit (Bromfield et al, 2010; p. 20).

Strategies for improving interagency collaboration include:

- Building better local networks which foster an understanding of the agencies that are operating in the local area. Getting to know the types of services they offer and the expertise of their workforce could be achieved by establishing a program of interagency network meetings, or information bulletins to share information; identifying interagency issues early; and to gain a better understanding of roles and responsibilities.
- Agreeing on better ways to work together to support shared clients might involve establishing a formal or informal network of service providers in a local area and actively undertaking joint case planning, case conferencing, or cross-agency referrals. These types of activities help providers to consider information about a child or a family from their respective professional disciplines, and to work out the best mix of supports for those clients.
- Establishing partnerships to develop integrated responses and address service delivery gaps. Through these partnerships a number of organisations can pool their resources and consolidate their efforts to responding to complex client programs that one agency alone cannot resolve. Existing partnerships can be built on to incorporate the principles of interagency collaboration.

"Collaboration can improve the overall effectiveness of services, for example, by moving parents toward a greater state of "readiness to change" through provision of ample emotional, psychological, and tangible support."

(Green et al. 2008, p.58).

Practice Point

Do you know the personnel from the local CSC?

To what extent is there a working relationship between your agency and FaCS?

What does your service do to enhance the relationship between FaCS and other agencies?

Is there a standard referral form and feedback process for use between the agencies?

- Establishing formal protocols to ensure that the roles and responsibilities of all parties are clear in supporting children and families in the local community by using memoranda of understanding to establish the basis for interagency collaboration where the interdependencies between agencies are accounted for and facilitated. Protocols can provide guidance for workers to engage with one another across agency and program boundaries.
- Creating opportunities for shared training which provide a strong foundation for interagency practice would improve understanding of agencies' respective roles and responsibilities, as well as promoting a shared language, knowledge and awareness between agencies.
- Recognising the function of strengthening relationships between agency partners within 'position descriptions'. For instance, FaCS requires that managers in CSCs establish and facilitate collaborative and innovative partnerships with community partners towards an integration of service delivery at the local level.

Practical ways in which organisations can work collaboratively include:

- identify and establish formal and informal communication networks with relevant organisations and build partnerships
- maintain current knowledge about local organisations
- use the information exchange provisions to gather relevant information relating to a child or young person's safety, welfare or wellbeing
- request the involvement of organisations where a need to work collaboratively has been identified
- discuss and reach agreement on how the collaborative arrangement will work, including the child, young person and their family
- nominate a 'key worker and/or organisation' to lead or oversee the collaborative arrangement, where required
- formalise collaborative relationships where necessary through policies, protocols or agreements
- establish mechanisms to resolve differences or disputes.

www.community.nsw.gov.au/kts/case-management/operation

Further recommendations arising from the needs analysis (LeeJenn, 2014) report:

- improve collaboration between AOD services and FaCS for women with children who are subject to care and protection orders
- establish Child Protection Coordinator positions to promote collaboration between the AOD sector and FaCS
- trial a program of staff outreach from a women's AOD service into FaCS office
- work with FaCS to identify satisfactory arrangements for women on a waiting list for a place in a specialist women's AOD service and who also have children that are subject to care and protection orders
- improve access to childcare for women receiving AOD treatment.

5.2.1 REFLECTIVE PRACTICE

The FaCS Care and Protection Framework involves 10 Practice Standards and includes a series of reflective questions for the CW to consider. Practice Standard 4 is particularly relevant to the interagency context as it focuses on collaboration between services. Within Standard 4, the key expectations are:

1. actively engage the child, young person, family and their network to participate in planning, actions, reviews and decision making
2. establish a thorough understanding of who the child/young person and family identify as their support network
3. establish, commit to and work on relationships with all informal and professional members of the family's network and community that are centred on the child
4. work with the child, young person, family and their network to agree on clear goals. Create positive change by working as a team
5. aid the child, young person and family to identify, access and engage with appropriate services
6. clearly identify and understand each service's role and responsibilities to help the family meet their goals
7. share relevant information with services currently or previously involved with the family.

The reflective prompts pertinent to Practice Standard 4 are as follows:

Have I...

- undertaken quality work and case planning that included the active participation of the child, young person, their family and network?
- actively supported the child/young person/family to engage with other services, rather than simply refer them?
- developed an effective relationship with the family's network (both formal and informal) and partnered together as a team with shared goals?
- shared relevant information with partner agencies?
- explained 'what, why and how' when decisions are made, with the child/young person, family and professional partners?
- arranged a case planning meeting whenever a change in circumstances occurs so that the family and interagency team can make decisions together?
- sought to develop a good understanding of local service networks and clarified roles and responsibilities?
- collaborated with colleagues in the unit to draw upon their knowledge, skills and experiences?

(Source: Care and Protection Practice Standards, OSP, FaCS)

Practice Point

Reflect on FaCs Care and Protection Framework Practice Standard 4.

To what extent do the seven key expectations parallel the expectations of your role when working with families?

Consider the reflective prompts listed within Practice Standard 4 in relation to your work in the context of parents and children.

"Fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare, and protect the safety of children"

(UK Government, 2015).

Practice Point

Does your service share a common language with FaCS?

Are there clearly identified channels of communication between your service and FaCS?

Are there clear processes and pathways between your service and FaCS?

How well do you understand existing legislation and protocols around information sharing?

5.3 Exchanging Information

Information exchange or sharing involves providing details about services, individual clients or groups of clients and their needs to another practitioner or agency and communicating with other practitioners to provide the best service possible to children and families in need.

There are currently two schemes for the exchange of information relating to the safety, welfare or wellbeing of children and young persons and unborn children under the Children and Young Persons (Care and Protection) Act 1998.

a. Chapter 16a

Chapter 16a came into force at the end of 2009. Under chapter 16a, prescribed bodies, including NGOs, justice agencies and human services, are able to share information relating to the safety, welfare or wellbeing of children or young people without consent where necessary, and whether or not the child or young person is known to FaCS.

b. Section 248

Section 248 allows FaCS to provide or request information relating to the safety, welfare and wellbeing of a child or young person. Section 248 contains strong powers of direction and discretion which are appropriate to FaCS' statutory role in relation to child safety and wellbeing. Information sharing under Section 248 also includes information in relation to an unborn child who has been the subject of a prenatal report under section 25 of the Act.

In 2006, NSW Health released a protocol in relation to information sharing between health services and Community Services in relation to people participating in opioid treatment who have care and responsibility for children under 16 years of age in order to assess potential risk of harm under the Children and Young Persons (Care and Protection) Act 1998. Information shared under this protocol and Section 248 of the Act, is intended to assist FaCS casework staff to assess the risk of harm to children that arises due to their potential exposure to methadone or buprenorphine.

For further information about information exchange and protocols refer to:

FaCS Legal Framework for Exchanging Information
www.community.nsw.gov.au/kts/guidelines/info-exchange/legal-framework

For a series of factsheets relating to Chapter 16A refer to:

www.community.nsw.gov.au/kts/reporting/?a=336077

For the NSW Health Information Sharing Protocol refer to:

www0.health.nsw.gov.au/policies/pd/2006/PD2006_085.html

A review of the national approach to child protection found that ideally, optimal information sharing involves informed consent, "as it is a prerequisite for maintaining trust, empowering families and increasing the likelihood of families staying involved in the process" (The Allen Consulting Group; p. xiii).

Key elements of optimal information sharing include:

"It is vital that we keep our sights firmly fixed on improving the outcomes for children and young people at the earliest possible time. Can there be a more important task?"

(Babington, 2011; p. 19)

- using a common language between service providers
- clear identification of formal arrangements and communication processes between organisations
- well-understood internal communication processes and pathways
- better understanding of existing legislation or protocols around information sharing.

Effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision.

Early sharing of information is the key to providing effective early help where there are emerging problems. At the other end of the continuum, sharing information can be essential to put in place effective child protection services. Review of child protection case files have shown how poor information sharing has contributed to the deaths or serious injuries of children.

Fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children. To ensure effective safeguarding arrangements:

- all organisations should have arrangements in place which set out clearly the processes and the principles for sharing information between each other, with other professionals and child protection services
- no professional should assume that someone else will pass on information which they think may be critical to keeping a child safe. If a professional has concerns about a child's welfare and believes they are suffering or likely to suffer harm, then they should share the information with child protection services.

(Source: Working together to safeguard children, UK Government, 2015)

5.4 Developing Protocols for Collaboration

It is important that AOD services and FaCS develop protocols for collaboration.

Role of AOD workers to support FaCS Case Management approach

- attendance at case meetings
- participation in case planning as necessary
- liaison with FaCS and other involved services in the relation to the family's wellbeing
- Attendance at court with client if requested
- Provision of written or verbal assessments of the parent's AOD use and its impact on general functioning.

Input of AOD Services into Case Planning

AOD workers may be involved in decisions regarding case planning and called on to provide initial written or verbal assessments of the parent's history of AOD use and its impact on general functioning. AOD workers may also be required to monitor and provide feedback to FaCS CWs on the parent's current AOD use. FaCS workers need to define the purpose of the case plan, any case meetings, outline the reasons why information about the adult's AOD use is essential to a comprehensive assessment of the child's safety and wellbeing. There is a need to clarify roles and responsibilities and the adult is clear about those roles (Victorian Department of Human Services, 2002).

6 RESOURCES AND GUIDELINES

Children of Parents with a Mental Illness Website

There are a number of eLearning and other resources available to access online, the COPMI (Children of Parents with a Mental Illness) national initiative develops information for parents, their partners, carers, family and friends in support of these children.

Website: www.copmi.net.au/

Clinical Guidelines for the Management of Substance Use During Pregnancy, Birth and the Postnatal Period.

NSW Ministry of Health (2014)

These guidelines contain information on the use of buprenorphine maintenance treatment during pregnancy; cannabis use in pregnancy; a recommendation for abstinence from alcohol during pregnancy; and updated information on child protection legislation in NSW.
Available at:
www0.health.nsw.gov.au/policies/gl/2014/GL2014_022.html

Family Focus Project Toolkit

Eastern Drug and Alcohol Service (2010).

The Family Focus Toolkit is a collection of selected resources including screening tools, questionnaires, worksheets, and utility practice tools gathered from the sector, research and professional bodies.

Available at:

http://nceta.flinders.edu.au/files/6513/0948/1146/EDAS_Family%20Focus%20Toolkit.pdf

Foetal Alcohol Spectrum Disorder and Justice Website

This site is designed for justice system professionals and others who want to understand more about FASD. It provides information and resources about FASD, including background information, case law, legal resources and strategies for effective intervention.

Website: http://fasdjustice.ca/

For Kids' Sake: A Workforce Development Resource for Family Sensitive Policy and Practice in the Alcohol and Other Drugs Sector

This toolkit aims to minimise cases of child abuse or neglect by increasing collaboration between child and adult service agencies. It aims to improve the safety and welfare of children with parents who misuse alcohol or drugs.

An NCETA workforce development resource available at:

http://nceta.flinders.edu.au/files/3913/0915/8536/EN435%20Battams%20et%20al%202010%20.pdf

NADA Practice Resource: Working with Women Engaged in Alcohol and Other Drug Treatment

This NADA resource is a practical guide to supporting workers and organisations to provide best practice interventions for women accessing AOD treatment. This includes effective organisational change, becoming a gender responsive service, supporting family inclusiveness and providing trauma informed care.

Available at:

http://nada.org.au/resources/nadapublications/resourcestoolkits/women'saodresource/

National Organisation for Foetal Alcohol Spectrum Disorder: NOFASD

NOFASD Australia is an independent not-for-profit charitable organisation. NOFASD are the national peak organisation representing the interests of individuals and families living with Fetal Alcohol Spectrum Disorders (FASD). The website provides information, training and support related to FASD.
Website: www.nofasd.org.au

Supporting Families Early Package – SAFE START Guidelines: Improving mental health outcomes for parents and infants

NSW Health, 2009

Safe Start is one of a suite of three documents aimed at integrating care for women, infants and families in the perinatal period. This document provides guidance on conducting psychosocial assessment, risk prevention and early intervention. Strategies to coordinate clinical responses to issues identified during assessment are also suggested, including effective responses to parental mental health problems and perinatal psychosocial issues, as well as advice on assisting mothers that have problems with substance use.

Available at:

http://www0.health.nsw.gov.au/policies/gl/2010/GL2010_004.html

Supporting Pregnant Women who use Alcohol or other Drugs: A guide for primary health professionals

National Drug and Alcohol Research Centre, 2014

This guide is intended for a range of health professionals, in a variety of settings to help support and provide information to pregnant women who use alcohol and other drugs. It also contains a detailed resource list of additional support services and resources.

Available at:

https://ndarc.med.unsw.edu.au/resource/supporting-pregnant-women-who-use-alcohol-or-other-drugs-guide-primary-health-care

The signs of safety: Child protection practice framework

WA Department of Child Protection (2011)

Is a policy document that seeks to create a more constructive culture around child protection organisation and practice. Central to this is the use of specific practice tools and processes where professionals and family members can engage with each other in partnership to address situations of child abuse and maltreatment.

https://www.dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/SignsOfSafetyFramework2011.pdf

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