PART III

CHILDREN AT RISK IN THE COMMUNITY
# IDENTIFICATION AND NOTIFICATION

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IDENTIFICATION AND NOTIFICATION

OVERVIEW

Abuse and neglect of children typically occur in private. Because most children are unable to protect themselves, they rely on interested and responsible adults who are close to them, such as friends, relatives, teachers or health practitioners, to identify signs of abuse and neglect. It is expected those adults will take steps to protect a child they suspect is, or is at risk of, being abused or neglected, and assist them to find safety. Reporting concerns to child protection authorities is an essential step in assisting to protect a child who is at risk.

In South Australia, some adults, by virtue of their profession or involvement with children, are legally obliged to report signs of abuse or neglect. These mandated notifiers form a critical part of the child protection system. Through notifiers an otherwise invisible child will come to the attention of child protection authorities.

The predominant role of the Families SA Call Centre is to receive notifications from mandated notifiers and other members of the community about the suspected abuse or neglect of children, and to conduct an initial assessment as to whether there should be a response to those concerns. As such, the Call Centre, commonly referred to as the Child Abuse Report Line or CARL, is the primary entry point to the child protection system. However, as outlined in this chapter, to consider this entry point as a typical customer call centre would misrepresent the critical and complex work undertaken by its practitioners.

This chapter examines how children at risk come to the attention of Families SA (the Agency), and consequently other government and non-government agencies through the process of notification. The rising demand for the Call Centre’s services must be addressed. The tools used, and thresholds applied, by practitioners when undertaking assessments must be reviewed. Against this background, the interface between notifiers and child protection authorities is significant. The need for Call Centre staff to be skilled and experienced practitioners is as important as the need for mandated notifiers to be able to identify the signs of abuse and neglect and to have a clear understanding of their role in the child protection system.

This chapter principally relates to the Commission’s Terms of Reference 5(a) and (b), in the context of Terms of Reference 1 to 4.

MANDATORY NOTIFICATION

GLOBAL TRENDS

Mandatory notification legislation began in the 1960s when jurisdictions in the United States enacted legislation that required medical practitioners to report suspected serious physical abuse inflicted by a child’s parent or caregiver.1

Since that time, mandatory notification legislation has spread through many countries, including Brazil, Canada, Denmark, France, Hungary, Israel, Norway, Saudi Arabia and Sweden. A 2013 survey of 73 countries (made up of 33 high-income, 33 medium-income and seven low-income countries) found that 61 per cent of high-income, 85 per cent of middle-income and 29 per cent of low-income countries had some form of mandatory notification legislation.2

There are notable exceptions: Germany, the Netherlands, New Zealand and the United Kingdom retain voluntary notification systems. However, these countries generally have industry policies that act as an alternative means of requiring members of relevant professions, such as doctors and teachers, to report suspected child abuse.3

The trend around the world appears to be towards some form of mandatory notification. Saudi Arabia recently introduced mandatory notification legislation and Ireland is in the process of so doing. There is a strong push in the United Kingdom to do the same.4

REPORTING DUTIES BY AUSTRALIAN JURISDICTION

In 1969, South Australia became the first Australian state to introduce mandatory notification legislation. That legislation now requires a wide range of employees and volunteers who work with children to notify Families SA if they suspect that a child is, or is at risk of, being abused or neglected.1

All other states and territories have now done the same, most recently Western Australia in 2009. However, as Table 7.1 and Table 7.2 show, significant differences remain between Australian jurisdictions in relation to:

- the range of people who must notify;
- the types of abuse and neglect they must notify; and
- the state of mind of the notifier.
<table>
<thead>
<tr>
<th>JURISDICTION</th>
<th>LEGISLATIVE PROVISION</th>
<th>STATE OF MIND</th>
<th>EXTENT OF HARM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Capital</td>
<td>Children and Young People Act 2008, s. 356</td>
<td>Believes on reasonable grounds</td>
<td>Any sexual abuse or non-accidental physical injury</td>
</tr>
<tr>
<td>Territory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New South Wales</td>
<td>Children and Young Persons (Care and Protection) Act 1998,</td>
<td>Suspects on reasonable grounds</td>
<td>Risk of significant harm, being current concerns for</td>
</tr>
<tr>
<td></td>
<td>ss. 23, 27</td>
<td></td>
<td>the safety, welfare or wellbeing of the child because of</td>
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<td></td>
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<td></td>
<td>the presence, to a significant extent, of:</td>
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<td></td>
<td></td>
<td></td>
<td>basic physical or psychological needs not being met;</td>
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<td></td>
<td></td>
<td></td>
<td>not receiving necessary medical care or education; physical or sexual</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>abuse or ill-treatment; exposure to domestic violence causing a risk of</td>
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<td></td>
<td></td>
<td></td>
<td>serious physical or psychological harm; serious psychological harm; the child</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>being subject to a prenatal report and the mother did not engage</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>successfully with support services</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Care and Protection of Children Act 2007, ss. 15, 26</td>
<td>Believes on reasonable grounds</td>
<td>Any significant detrimental effect caused by any act,</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>omission or circumstance on the physical, psychological or</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>emotional wellbeing of the child</td>
</tr>
<tr>
<td>Queensland</td>
<td>Child Protection Act 1999, ss. 9, 13E.</td>
<td>Becomes aware of, or reasonably suspects</td>
<td>Significant detrimental effect on the child’s physical, psychological or</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>emotional wellbeing</td>
</tr>
<tr>
<td>South Australia</td>
<td>Children’s Protection Act 1993, ss. 6, 11</td>
<td>Suspects on reasonable grounds</td>
<td>Any sexual abuse; physical or psychological abuse or neglect to the extent</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>that the child has suffered, or is likely to suffer, physical or psychological</td>
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<td></td>
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<td></td>
<td>injury detrimental to the child’s wellbeing; or the child’s physical</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>or psychological development is in jeopardy</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Children, Young Persons and their Families Act 1997, ss.</td>
<td>Believes or suspects on reasonable</td>
<td>Any sexual abuse; physical or emotional injury or other</td>
</tr>
<tr>
<td></td>
<td>13-14</td>
<td>grounds, or knows</td>
<td>abuse, or neglect, to the extent that the child has suffered, or is likely</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>to suffer, physical or psychological injury detrimental to the child’s</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>wellbeing; or the child’s physical or psychological development is in jeopardy</td>
</tr>
<tr>
<td>Victoria</td>
<td>Children, Youth and Families Act 2005, ss. 162, 184</td>
<td>Believes on reasonable grounds</td>
<td>The child has suffered, or is likely to suffer, significant harm as a result</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>of physical injury or sexual abuse and</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>the child’s parents have not protected, or are unlikely to</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>protect, the child from harm of that type</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Children and Community Services Act 2004, s. 124B</td>
<td>Believes on reasonable grounds</td>
<td>Any sexual abuse</td>
</tr>
<tr>
<td>Commonwealth</td>
<td>Family Law Act 1975, ss. 4, 67ZA</td>
<td>Suspects on reasonable grounds</td>
<td>Any assault or sexual assault; serious psychological harm; serious neglect</td>
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<thead>
<tr>
<th>JURISDICTION</th>
<th>LEGISLATIVE PROVISION</th>
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<th>DOCTORS</th>
<th>NURSES</th>
<th>OTHERS</th>
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</thead>
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<tr>
<td>Australian Capital Territory</td>
<td>Children and Young People Act 2008, s. 356</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Dentists, midwives, home education inspectors, school counsellors, childcare centre carers, home-based care officers, public servants working in services related to families and children, the public advocate, the official visitor, paid teachers' assistants/aides, paid childcare assistants</td>
</tr>
<tr>
<td>New South Wales</td>
<td>Children and Young Persons (Care and Protection) Act 1998, s. 27</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>A person who, in the course of his or her professional work or other paid employment, delivers health care, welfare, education, children’s services, residential services, or law enforcement, wholly or partly, to children (and managers in organisations providing such services)</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Care and Protection of Children Act 2007, s. 26</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>All persons</td>
</tr>
<tr>
<td>Queensland</td>
<td>Child Protection Act 1999, s. 13E</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Persons engaged as child advocates</td>
</tr>
<tr>
<td>South Australia</td>
<td>Children’s Protection Act 1993, s. 11</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Pharmacists; dentists; psychologists; community corrections officers; social workers; religious ministers (but not information communicated in a confessional); employees and volunteers in religious or spiritual organisations; teachers in educational institutions (including kindergartens); family day care providers; and employees and volunteers in organisations providing health, welfare, education, sporting or recreational services to children or who deliver or supervise the delivery of those services to children or hold a management position in the organisation</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Children, Young Persons and their Families Act 1997, s. 14</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Midwives, dentists, psychologists, probation officers, principals and teachers, childcare providers, and employees and volunteers in government-funded agencies providing health, welfare or educational services to children</td>
</tr>
<tr>
<td>Victoria</td>
<td>Children, Youth and Families Act 2005, s. 182</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Midwives; school principals; certain officers of children’s services; people with prescribed post-secondary qualifications working in health, education, community or welfare services; youth and child welfare officers; psychologists; youth parole officers; youth justice officers</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Children and Community Services Act 2004, s. 124B</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Midwives</td>
</tr>
<tr>
<td>Commonwealth</td>
<td>Family Law Act 1975, s. 672A</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Some Family Court or Federal Court staff, family consultants, family counsellors, family dispute resolution practitioners, arbitrators, children’s lawyers</td>
</tr>
</tbody>
</table>

The first mandatory notification legislation in South Australia applied only to medical practitioners, dentists and others groups proclaimed by the Governor. It required them to report suspected criminal ill-treatment of children under the age of 12 years that was committed by parents or caregivers. The duty has since widened considerably. Section 11 of South Australia’s Children’s Protection Act 1993 (the Act) requires mandated notifiers to notify the Department if they ‘suspect on reasonable grounds’ that a child has been or is being abused or neglected, and the suspicion is formed in the course of the person’s work (whether paid or voluntary). They must notify the Department as soon as practicable after forming the suspicion.

The Act defines ‘abuse or neglect’ to include:

• sexual abuse of the child;
• physical or emotional abuse of the child, or neglect of the child, to the extent that the child has suffered or is likely to suffer, physical or psychological injury detrimental to the child’s wellbeing; or the child’s physical or psychological development is in jeopardy; and
• a reasonable likelihood of the child being killed, injured, abused or neglected by a person with whom the child resides.

This is similar to the position in New South Wales, the Northern Territory and Tasmania, although those jurisdictions also refer to the exposure of children to family violence, which is covered in South Australia by the concept of ‘emotional abuse’. By contrast, the duty in the Australian Capital Territory, Queensland, Victoria and Western Australia is generally limited to reporting physical and sexual abuse.

The groups required to notify in South Australia have also expanded. The most recent expansion followed the 2003 Layton Review which, in effect, recommended that all people who work with children, in either paid or voluntary capacities, be required to notify. Accordingly, the duty now applies in South Australia to the wide group of community members listed in Table 7.2. Apart from the Northern Territory, where all adults must notify suspected abuse or neglect, South Australia has the nation’s widest range of mandated notifier groups.

THE FUTURE OF THE DUTY TO NOTIFY

There is debate about the growth of mandatory notification legislation into areas such as emotional abuse and neglect. Some argue that this has encouraged large numbers of unnecessary notifications that overwhelm child protection agencies, divert resources from more serious child protection concerns, intrude unnecessarily in the lives of ordinary families and focus resources on forensic investigations, rather than helping families and preventing concerns from escalating.

Recent child protection inquiries in Australia have supported the maintenance or expansion of mandatory notification, including in South Australia in 2003, the Australian Capital Territory in 2004, the Northern Territory in 2007, New South Wales in 2008, Victoria in 2012 and Queensland in 2013. A 2007 inquiry in Western Australia recommended that mandatory notification should not be enacted. Nevertheless, mandatory notification of sexual abuse was introduced the following year.

There is no doubt that children exposed to emotional abuse and neglect sustain profound, long-term physical and psychological damage. The groups mandated to notify under South Australian legislation are well placed to identify and report early signs of these types of abuse.

Experience indicates that voluntary notification is not enough. A range of factors make notifiers reluctant to report, including:

• the fear that their suspicion is misplaced;
• the fear that a notification will make matters worse, anger the family or harm a therapeutic relationship;
• an unwillingness to become involved; and
• a lack of confidence in the child protection system.

Mandatory notification makes the duty plain and is an important statement about the community’s commitment to protect children from all forms of harm.

Evidence suggests that mandatory notification is effective, in that it tends to identify cases of abuse and neglect that would otherwise not come to light. Most cases of child maltreatment—whether physical, sexual or emotional abuse or neglect—are identified as a result of a report by a mandated notifier. Non-mandated notifiers make a ‘significant but far smaller contribution to case identification’. Countries with mandatory reporting tend to have higher rates of substantiated abuse or neglect than countries without mandatory reporting.

Most abuse and neglect occurs in private. Victimised children rarely report their own situation. They need caring adults committed to notify on their behalf.

As discussed in this chapter, the rising numbers of notifications present a significant resourcing challenge for the child protection system. Better training and alternative sources of advice for mandated notifiers may moderate demand and improve the general quality of notifications. However, as discussed below, claims that a large number of notifications are unnecessary appear to be exaggerated. Many notifications that are presently assessed as not requiring a response are in fact important matters that need to be brought to the attention of child protection authorities.
Proposals to narrow the legislative duty on mandated notifiers tend to assume this would necessarily change notifier behaviour. However, the factors that lead a notifier to report are complex and interrelated, including not only the legislative duty, but also notifier training, system characteristics and reporting culture. There is little research about the empirical effects of mandatory notification legislation on over-reporting. The available evidence does not suggest that amending any particular element of the legislative duty would improve the quality of notifications or reduce the burden on the system. It is tempting to conclude that behavioural change would not follow statutory change. It is worth noting when New South Wales increased its notification threshold in 2010 to a ‘risk of significant harm’ [emphasis added], notifications to the statutory helpline reduced. However, most were diverted to the state’s Child Wellbeing Units for a ‘differential response’. This shifted the destination of notifications, but did not reduce overall demand on the system. Notifiers continued to notify by default, rather than considering options to support families and there was ‘considerable “gaming” of the system’ by notifiers to ensure that children met the revised threshold at the helpline and therefore received a statutory response.16

There is a need to emphasise to notifiers that mandatory notification is not the end of their duty. It is important to encourage the whole community, including government and non-government agencies already engaged in the lives of families, to consider how they might better support families and children at risk and to view themselves as joint partners in the broader child protection system. The Commission is however satisfied that the existing duty on mandated notifiers in South Australia to bring at risk children to the attention of the system should be maintained. Chapter 8 recommends significant changes to the way this duty is discharged.

SATISFYING THE DUTY

The Act provides that mandated notifiers must notify ‘the Department’, defined as ‘the administrative unit of the Public Service prescribed by regulation for the purposes of this definition’.17 The Act does not specify how mandated notifiers should notify. Nor does it specify who in the Department should be notified. On one view, a notifier ‘notifies the Department’ by telling any officer in the Department. For example, a teacher in a departmental school arguably complies by informing the school principal. That position was never intended.

Families SA operates a 24-hour Call Centre to receive notifications of abuse or neglect by telephone or the internet. Practitioners in the Call Centre are ostensibly trained and equipped to receive and assess notifications. In practice, and as a matter of Families SA policy, this is how mandated notifiers satisfy the duty to notify.

FUNCTIONS OF THE FAMILIES SA CALL CENTRE

The Families SA Call Centre is the primary means by which professional notifiers and members of the public bring child protection concerns to the attention of Families SA. Call Centre practitioners assess the concerns to determine whether they should receive a response and, if so, the nature and timeframe of that response.

The Call Centre operates a number of telephone numbers. They include:

• a general line used by mandated notifiers and members of the public. The Call Centre generally answers these calls in order of how long the call has waited, but with some priority to calls from police officers;
• a dedicated line for police officers, the two hospital-based Child Protection Services and hospital emergency departments to use in genuine emergencies. This line is answered almost immediately; and
• a dedicated line for Families SA staff who need to discuss assessments made by the Call Centre. This line is answered by supervisors or senior practitioners.

Together, these lines are commonly known as the Child Abuse Report Line (CARL). The Call Centre also operates the electronic Child Abuse Report Line (eCARL) service, which allows notifiers to report suspected abuse or neglect over the internet.

Between 4pm and 9am Monday to Friday, and 24 hours a day on weekends and public holidays, the Call Centre operates an after-hours Crisis Care service for families and individuals in crisis. When the Crisis Care service is operating, Call Centre practitioners divide their time between assessing telephone and eCARL notifications and responding to crisis care requests.

HOW NOTIFICATIONS ARE ASSESSED

SCREENING IN AND SCREENING OUT

Whether a notification is made by telephone or eCARL, Call Centre practitioners assess the notification and determine the appropriate response by first determining which matters are ‘screened in’ to enter the child protection system and which are ‘screened out’, which means they do not receive a response from Families SA. The practitioners then apply a tier rating to all screened-in notifications to determine how quickly Families SA should respond.18

In addition to recommending changes to how the mandatory duty to notify is discharged, Chapter 8 also recommends legislative change to make clear to whom a notifier must report their concerns.
A notification is screened in for response if it constitutes physical, sexual or emotional abuse or neglect by the child’s parent or caregiver. Practitioners are guided in this decision by the Structured Decision Making® (SDM) screening criteria and definitions (the screening tool). The screening tool contains more than 50 specific grounds of physical, sexual and emotional abuse and neglect, and provides a detailed definition for each ground. If the information in the notification falls within one or more of these grounds, it is screened in for a response.

The screening tool effectively distinguishes between the types of adversity that children commonly experience from time to time and that many families are able to deal with, and unacceptable abuse and neglect from which all children are entitled to be protected. It uses words including ‘serious’, ‘significant’, ‘extreme’, ‘immediate’ and ‘repeatedly’ to quantify the level of risk or harm a child must experience for it to constitute abuse or neglect.

GROUNDS FOR SCREENING OUT NOTIFICATIONS

There are also a number of grounds that, if applicable, result in a notification being screened out, including the following:

- Notifier Only Concern (NOC)—the notification is insufficient or vague, the notifier lacks credibility or the notification does not meet the definition of abuse or neglect.
- No Grounds for Intervention (NGI)—the concern meets the threshold, but there is no need for Families SA to respond because the event is historical, another agency is addressing the matter or the perpetrator no longer has contact with the child and the caregiver is protective. The child must be safe from further harm.
- Divert Notifier Action (DNA)—the concerns meet the definitional threshold, but the notifier has agreed to intervene with the family to address the protective issues/concerns.
- Adolescent at Risk (AAR)—the notification identifies an adolescent at risk of harm from their own behaviour or a set of circumstances, such as homelessness, drugs or alcohol, family conflict, self-harm or suicidal ideation.
- Extra-familial Cases (EXF)—the alleged perpetrator is not the child’s parent or carer. Practitioners must consider whether there are intra-familial concerns related to a failure of the caregiver to protect the child.
- Report on Unborn (ROU)—there is high risk to an unborn child and the mother is within six weeks of giving birth (34 weeks’ gestation).

Screened-out notifications do not generally receive a response from Families SA. AAR and ROU matters are referred to Families SA Assessment and Support teams where they sometimes receive a response. Some AARs are referred on to other agencies, such as Streetlink or the Metropolitan Aboriginal Youth and Family Services. EXF matters are referred to South Australia Police.

TIER RATINGS FOR PRIORITISING SCREENED-IN MATTERS

Next, the Call Centre assigns a response priority to all screened-in notifications in the form of a tier rating. (Screened-out notifications do not receive a tier rating.) The rating determines what type of response the notification should receive and how quickly the investigation, assessment or other response should start.

Practitioners are assisted in this task by the SDM Response Priority Assessment: Assessment, Policy and Procedures (the response priority tool). The tool contains decision trees based on actuarial measures to help assess how urgently risks facing children need to be addressed. The decision trees ask a series of questions that ultimately lead to the following tier rating:

- Tier 1 intakes require an emergency response within 24 hours because the child is in immediate danger or at imminent risk of serious harm.
- Tier 2 intakes involve a moderate to high risk of significant harm and require a response within five or 10 days, depending on the circumstances. If the child is 12 months or younger, the response should be within three days.
- Tier 3 intakes involve ‘low risk of further harm or low-level care concerns, but there may be high needs which, if not addressed, might have long-term detrimental effects on the child’. There is no set timeframe for responding to Tier 3 intakes.

As discussed in Chapter 9, the response timeframes are misleading, because most screened-in notifications are currently Closed No Action, a closure code that indicates that Families SA has closed the notification without taking any action.

The tier rating also determines the type of response that Families SA should provide. Families SA policy provides that Tier 1 and 2 intakes are generally investigated. Tier 3 intakes should receive a ‘community response’ which, until recently, generally meant an invitation by letter to attend a meeting at a Families SA office. As discussed in Chapter 8, the Linking Families team, which started in mid-2015, now generally responds to Tier 3 cases by letter or telephone.
THE RISING NUMBERS OF NOTIFICATIONS

In 2003, the Layton Review observed that South Australia, like every other jurisdiction in Australia, was experiencing rising numbers of child protection notifications. It noted that notifications in Australia increased from 91,734 in 1995/96 to 137,938 in 2001/02, a rise of about 50 per cent.27

Since then, notifications have continued to rise across Australia. In 2010/11, notifications in Australia totalled 237,273. In 2014/15, they increased to 320,169, a rise of 35 per cent. Between 1995/96 and 2014/15, notifications increased by 349 per cent.28

In South Australia, as Table 7.3 shows, total notifications have also risen in each of the past four years. In 2011/12, 40,507 notifications were received, increasing in 2014/15 to 57,810, a rise of about 40 per cent. In the same period, screened-in notifications also rose, albeit more slowly. There were 17,290 screened-in notifications in 2011/12, growing to 19,160 in 2014/15, a rise of nearly 11 per cent.

Table 7.3: Screened-in notifications and Notifier Only Concerns as a percentage of total notifications, 2011/12 to 2014/15

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total notifications</td>
<td>40,507</td>
<td>43,539</td>
<td>48,837</td>
<td>57,810</td>
</tr>
<tr>
<td>Screened-in notifications* (percentage of total)</td>
<td>17,290 (43%)</td>
<td>16,947 (39%)</td>
<td>16,932 (35%)</td>
<td>19,160 (33%)</td>
</tr>
<tr>
<td>Notifier Only Concerns (percentage of total)</td>
<td>16,239 (40%)</td>
<td>18,072 (42%)</td>
<td>22,048 (45%)</td>
<td>27,965 (48%)</td>
</tr>
</tbody>
</table>

* For the purposes of this report, ‘screened-in notifications’ are limited to Tier 1, Tier 2 or Tier 3 intakes, excluding Extra-familial Cases (EXF). EXF, although technically ‘screened in’ for some statistical purposes, are referred to South Australia Police.

A RISING THRESHOLD FOR INTERVENTION?

Table 7.3 shows that the proportion of screened-in notifications declined from 43 per cent of all notifications in 2011/12 to 33 per cent in 2014/15. Notifier Only Concerns (NOCs) rose in corresponding terms from 40 per cent of all notifications in 2011/12 to 48 per cent in 2014/15.

As shown in Table 7.4, in the same period that NOCs grew as a proportion of all notifications, the proportion of screened-in notifications classified as Tier 3 declined from 13 per cent in 2011/12 to 7 per cent in 2014/15. In the same period, Tier 2 notifications increased in absolute number and as a proportion of screened-in notifications.

Table 7.4: Response priority (tier) ratings as a percentage of screened-in notifications, 2011/12 to 2014/15

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screened-in notifications</td>
<td>17,290 (8%)</td>
<td>16,947 (9%)</td>
<td>16,932 (7%)</td>
<td>19,160 (6%)</td>
</tr>
<tr>
<td>Tier 1 (percentage of total)</td>
<td>1387</td>
<td>1506</td>
<td>1156</td>
<td>1061</td>
</tr>
<tr>
<td>Tier 2 (3 days infant)</td>
<td>3172</td>
<td>2908</td>
<td>3100</td>
<td>3611</td>
</tr>
<tr>
<td>Tier 2 (5 days)*</td>
<td>1296</td>
<td>5949</td>
<td>6498</td>
<td>7611</td>
</tr>
<tr>
<td>Tier 2 (10 days)</td>
<td>9119</td>
<td>4682</td>
<td>4712</td>
<td>5565</td>
</tr>
<tr>
<td>All Tier 2 (percentage of total)</td>
<td>13,587 (79%)</td>
<td>13,539 (80%)</td>
<td>14,310 (85%)</td>
<td>16,787 (88%)</td>
</tr>
<tr>
<td>Tier 3 (percentage of total)</td>
<td>2316 (13%)</td>
<td>1902 (11%)</td>
<td>1466 (9%)</td>
<td>1312 (7%)</td>
</tr>
</tbody>
</table>

* The Tier 2 (5 days) rating was established in late 2011 (Families SA, ‘Divisional circular no. 161’, internal unpublished document, Government of South Australia, 2011).

Source: Data provided by Families SA.
Table 7.5 provides an historical comparison of notifications from 1998/99 to 2001/02, the period examined by the Layton Review.

Table 7.5: Response priority (tier) ratings as a percentage of total notifications, 1998/99 to 2001/02

<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Total notifications</td>
<td>13,132</td>
<td>15,181</td>
<td>16,314</td>
<td>18,681</td>
</tr>
<tr>
<td>Screened-in (percentage of total)</td>
<td>8218 (63%)</td>
<td>8627 (57%)</td>
<td>8854 (54%)</td>
<td>9872 (53%)</td>
</tr>
<tr>
<td>Tier 1 (percentage of screened in)</td>
<td>419 (5%)</td>
<td>358 (4%)</td>
<td>500 (6%)</td>
<td>778 (8%)</td>
</tr>
<tr>
<td>Tier 2 (percentage of screened in)</td>
<td>5884 (72%)</td>
<td>5961 (69%)</td>
<td>5821 (66%)</td>
<td>6382 (65%)</td>
</tr>
<tr>
<td>Tier 3 (percentage of screened in)</td>
<td>1915 (23%)</td>
<td>2308 (27%)</td>
<td>2533 (29%)</td>
<td>2712 (27%)</td>
</tr>
</tbody>
</table>

Note: The term ‘CP reports’ in the Layton Review appears to correspond to ‘total notifications’ as used elsewhere in this report. For comparison purposes, ‘screened-in notifications’ continue to include only Tier 1, 2 and 3 matters.


The decline in Tier 3 ratings and the rise in NOCs may suggest the Call Centre’s practice has shifted to classify lower level concerns as NOCs, rather than Tier 3 intakes. For example, it is possible that:

> working definitions of what constitutes ‘risk’ and ‘safety’ are influenced by the pressure of demand, rather than having any fixed meaning that arises from an evidence-based approach to practice.30

Whatever the cause, the result is a hollowing out of lower level concerns from the child protection system, with fewer families and children receiving a response unless the concerns escalate.

AN ASSESSMENT OF SCREENED-OUT NOTIFICATIONS

DIVERSION OF RESOURCES OR OPPORTUNITY FOR EARLY SUPPORT?

Screened-out notifications are sometimes regarded as matters that do not need to be reported and that divert limited resources away from more deserving child protection matters.31 A recent newspaper article described about half of all telephone calls to the Families SA Call Centre as ‘unnecessary’.32 Some witnesses told the Commission that some notifiers are ‘risk averse’ and report too readily in order to transfer responsibility to Families SA33:

> We’ve become an agency for the protection of the mandated notifier rather than the child ... over half our daily work is not a genuine or reasonable belief that a child is at risk or has been harmed.34

While this criticism may have merit in some specific cases, the Commission considers it is too simplistic. There are at least three reasons why the Agency needs to receive many—quite likely, most—of the notifications that its Call Centre is screening out. First, they are an opportunity to provide early intervention and support to families in need. They are ‘ideal candidates for service provision to prevent a continuance or escalation of maltreatment’.35

Second, the notifications allow the Agency to build a more complete picture of the family and may later provide vital background information, intelligence and context if further concerns arise.

Third, they allow the Agency to offer support and guidance to members of the community and government and not-for-profit agencies who are providing primary assistance to the family.
IDENTIFICATION AND NOTIFICATION

NOTIFIER ONLY CONCERN (NOC)

As shown in Table 7.3, notifications screened out as NOCs have risen from 40 per cent of all notifications in 2011/12 to 48 per cent in 2014/15.

During the course of its Intake review (see methodology in Appendix C), the Commission examined 20 notifications screened out as NOCs, including the following:

- A seven-year-old child, with ongoing poor hygiene, dirty clothes, wrong-sized shoes and chronic head lice, was 'very emotional', 'easily angered' and said 'no one loves her'. She was isolated and her grandfather told her that she could only have one friend: him. She was tired because she shared a mattress on the floor with siblings and dogs ran around the house. There were 14 prior notifications for the family, including an allegation that her elder sibling was raped and her grandfather permitted ongoing contact with the perpetrator. The child had also previously disclosed that her brother tried to kill her.
- A mother had full-time care of two primary school-aged children, but used the drug 'ice' and sometimes passed out. She did not always cook dinner.
- A 13-year-old boy smashed glass doors at his house and tried to strangle his sisters. The mother did not let the repairer inside to repair the doors. The children had poor school attendance and limited food for breakfast and lunch. There were longstanding concerns, including neglect, exposure to domestic violence, drug and alcohol use, and the mother's poor mental health.
- A father when drunk had made threats towards the children and the mother, who locked themselves in a room. They left in the morning, but were shaken and the nine-year-old child felt sick. The mother contacted emergency accommodation. The parents had a history of violence, including the mother in her previous relationships. The 10-year-old child had a history of self-harm and aggressive behaviour.
- Police attended an argument between two parents who each wanted to sleep in rather than prepare breakfast for the children. The mother screamed throughout the police attendance. One child was upset and cried the whole time. The parents smoked marijuana every day, but decided to stop, which is why the mother lost her temper. The mother was isolated and had no money. She planned to drive until petrol. The father was unaware of the situation when he collected the child from school. The family had no child protection history.
- A five-year-old child attended school late and required a change of clothes because they were soaked with petrol. The father was unaware of the situation when he collected the child from school. The family had no child protection history.

The Commission considered that 15 of the 20 screened-out notifications needed assessment within about a week and should have been screened in as Tier 2 intakes. Another three required assessment, but less urgently and should have been screened in as Tier 3 intakes. The Commission found that only two of the 20 matters would not have required a response by Families SA.

The phrase ‘notifier only concern’ suggests that any concerns are misplaced or somehow idiosyncratic to the notifier. Yet, when it is used to describe almost half of all notifications (27,965 in 2014/15), it raises the question of whether Families SA’s screening-in threshold is too high. Matters such as those extracted above should not be referred to as Notifier Only Concerns. To the contrary, they are cases suggestive of children at significant risk of serious harm. They require an assessment by Families SA to determine the level of risk, the needs of the family, and what intervention or support is required to keep the children safe from harm.

NO GROUNDS FOR INTERVENTION (NGI) OR DIVERT NOTIFIER ACTION (DNA)

About five per cent of all notifications are classified as NGI or DNA. They are usually matters that would meet the threshold for intervention, but are screened out because Families SA or another agency is already assisting the family. In some cases, the notifier is assisting the family, but is seeking further guidance and ensuring Families SA is aware of the situation.

During the course of its Intake review, the Commission examined 20 notifications screened out as NGI, including the following:

- The mother had a history of mental health problems, drug and alcohol abuse, and domestic violence relationships. She had stopped taking her mental health medication, was experiencing anxiety and suicidal thoughts, and had recently smashed a glass and punched a hole in the wall in the presence of her five-year-old child. The mother was receiving support from a not-for-profit agency and a mental health provider.
- Six children aged two to 13 years were living in squalid conditions, with old food, mould, rats and cockroaches. They had many health issues, including lice, sores and scabies, and were often under-dressed for the weather. The mother was unwell and felt depressed. One child was often late for school and suffered from poor hygiene and incontinence. The father had a history of violent and aggressive...
behaviour, and criminal offending. The parents had a history of abusing drugs and alcohol, domestic violence, poor supervision and chronic neglect. The children had unexplained injuries. The family were supported by a not-for-profit agency that reported some inroads regarding cleanliness of the house.

- The mother had not booked appointments at the dentist and optometrist for her primary school-aged children, despite frequent reminders and home visits. The children were at risk of harm due to neglect, but the family was being supported by a number of not-for-profit agencies.

In each of these cases, the notification was screened out on the basis that an agency was already supporting the family. However, the interventions were not mitigating the risk to the children. The child protection concerns remained or were escalating. In some cases, the support agency itself was notifying Families SA of the increasing risk. Such cases should not be permitted to drift. A more proactive assessment is called for to determine what further intervention is required and to coordinate the agencies already involved.

The Commission considered that four of the 20 NGI notifications it reviewed required assessment within about a week and should have been screened in as Tier 2 intakes. Another five required assessment, but less urgently and should have been screened in as Tier 3 intakes. Nine notifications related to open Families SA child protection files: this information could have informed the ongoing casework. The Commission found that only two matters did not require a response.

**ADOLESCENT AT RISK (AAR)**

Between six per cent and eight per cent of notifications are classified as AAR.

During the course of its Intake review, the Commission examined 20 notifications screened out as AAR, including the following:

- A 17-year-old child’s father was getting drunk and calling her a ‘bitch’ and a ‘slut’. She was cutting herself and had suicidal thoughts.
- A 14-year-old child was found walking alone at 3am, carrying cannabis, which he smoked ‘to relax’. The child did not seem upset, but was cold and asked for a lift. His mother was not concerned regarding the cannabis or him walking the streets at that time. The parents had a history of severe domestic violence, to which the child was exposed and during which he was physically injured. The mother had a history of drug use, and verbal and physical abuse of the child. The child had poor school attendance and exhibited disruptive, sexualised behaviour.

- A 16-year-old girl residing in a small residential care home was supplied with ‘acid’ by another resident. They went ‘tripping’ together at 4am and engaged in consensual sexual activity in bushes.
- A 13-year-old had been using marijuana since she was nine and had a history of self-harm. Her father did not supervise her as he spent most of his time in his bedroom, where he smoked marijuana and ‘crack’. He had a glass pipe on his bedside table. Although the mother no longer lived with the family, the parents had a history of domestic violence and the mother had a long history of intravenous drug use, to which the child was exposed.
- A 14-year-old child said her father continued to use heroin; she was petrified of him and did not want to live with him because he verbally and physically abused her. The notifier described the father as ‘pure evil’. The child had a history of suicidal ideation and was taking medication for depression. The father had a history of drug and alcohol abuse, poor mental health, domestic violence and physical child abuse.

These cases are suggestive of children at significant risk of serious harm. The Commission considered that seven of the 20 AAR notifications it reviewed required assessment within about one week and should have been screened in as Tier 2 intakes. Another nine required assessment, but less urgently and should have been screened in as Tier 3 intakes. Another two related to open Families SA child protection files, where assessment was ongoing.

Three of the 20 AAR notifications related to children already in care. These were clearly matters that needed to be reported. As outlined in Chapter 10, Families SA carries a special burden to ensure these children experience the best possible care and therapeutic interventions to give them every opportunity to reach their full potential.

Children who are the subject of AAR notifications are often among the most distressed, disadvantaged and vulnerable in the state. Many face complex challenges and exhibit complex behaviours that are not easy to resolve. Of course, many have experienced significant abuse and neglect as younger children and their complex behaviours are a predictable consequence of past trauma.

The circumstances surrounding some screened-out AAR notifications examined by the Commission were difficult to distinguish from screened-in notifications relating to younger children. In those cases, Families SA appeared to apply a higher threshold to screening-in notifications concerning adolescents than younger children.
One witness stated that the Call Centre gives ‘a relatively lower priority’ to child protection concerns involving adolescents. A submission to the Commission emphasised that older youth, particularly those over the age of 12 years ‘are unlikely to receive an intervention unless they are already in the care system’.

Children of all ages are entitled to safety from harm and the opportunity to reach their full potential. The Commission considers that the AAR classification should be restricted to cases where the risk to a child is genuinely related to their own risk-taking behaviour. Children of any age who experience neglectful or abusive care should be screened in for a response.

**EXTRA-FAMILIAL (EXF)**

About five per cent of notifications are classified as EXF because the risk to the child lies outside the family. Families SA refers these matters to South Australia Police. It is important to note that many EXF notifications also give rise to screened-in notifications where there are also intra-familial risks, such as the caregivers not being protective of the child. In any event, the Commission considers that EXF notifications are generally matters that need to be reported.

**REPORT ON UNBORN (ROU)**

ROU matters represent about one per cent of all notifications. Families SA describes them as ‘essentially “advance notice” of a High Risk Infant’ and policy requires that ROUs only be recorded from 34 weeks’ gestation. One experienced Families SA Call Centre practitioner expressed concern that ROUs were sometimes recorded earlier than 34 weeks, as ROUs create thousands of case files for individuals who may never be born and most of whom will not be Families SA clients.

The pre-birth period is, however, a time in which many families are receptive to therapeutic input. Parents tend to identify with their baby in utero and are more likely to be motivated to make changes. Requirements of a minimum period of gestation for a ROU notification jeopardises a critical engagement period and only delays this important work. ROU matters are an opportunity to support many expectant parents, and this outweighs the fact that some pregnancies may not result in a live birth.

In Victoria and New South Wales, specific reference is made in legislation to notifiers reporting concerns of a risk of harm with respect to unborn children. In each case the concern held must relate not to current safety of the unborn child, but to concerns about their safety after birth. Although there is no legislative impediment to such reports in this state, the manner in which reports have been dealt with at a policy level highlights the need for clarity. The reporting and recording of concerns should be encouraged as early as possible. Legislation should specifically permit, rather than oblige, notifiers to report concerns about unborn children, regardless of the stage of pregnancy, in circumstances when it is presently necessary to offer services and supports to the mother to improve outcomes, or to have a properly planned child protection response, when the child is born. Correspondingly, the policy restricting the recording of ROU matters until 34 weeks’ gestation must be abandoned.

**IGNORING SCREENED-OUT NOTIFICATIONS CAN BE DANGEROUS**

It is potentially dangerous and not appropriate to regard screened-out notifications simply as unnecessary distractions from Families SA’s core business. They involve many matters that need to be reported for a variety of reasons, including:

- there is an open Families SA file and the notification would form part of the ongoing assessment;
- the notification, although not requiring a response, might offer a more complete picture of the family, which might assist in future assessments;
- the notifier is working with the family and might require support and guidance. This could be an opportunity for Families SA or another agency to help coordinate the intervention; and
- despite the screening assessment, the child appears to be at risk and further assessment is required to determine their safety. In some cases, the assessment might be brief and somewhat informal, with a focus on identifying the needs of the family and referring them to a support agency that could meet those needs. However, without some form of assessment, there can be no confidence that the child is safe.

The Intake review revealed that the vast majority of the 60 notifications screened out as NOC, NGI or AAR were serious matters that needed to be reported. Forty-three of the 60 matters appeared to involve children at significant risk of serious harm, who required assessment. A further 11 notifications related to open Families SA files and would have informed ongoing assessments. The Commission considered that only six matters did not require a response.

It is not possible to express any final conclusions based on such a small sample. However, it is clear that more work is needed to ensure the Agency is applying the correct practical threshold for intervention. This is particularly the case given the concerns discussed below that the screening and response priority tools give insufficient weight to important issues such as neglect and cumulative harm. Currently, more than half of all notifications are assessed as ‘notifier only concerns’. It is naive to assume that so many notifiers are applying the wrong threshold, without reflecting on whether Families SA itself has the balance right.
FAMILIES SA RECORDING PRACTICES

INACCESSIBILITY OF LOG SHEETS

Families SA Call Centre practitioners complete a handwritten log sheet when they receive telephone notifications. After the telephone call, the practitioner enters the data from the log sheet into the case management system, C3MS. The log sheets are then physically archived. They are not scanned into C3MS and are not readily accessible to Families SA workers. They are usually only retrieved when requested by the Coroner or other inquiries.43

During its Intake review, the Commission sought to retrieve the relevant log sheets. Families SA advised that it would take one staff member about one month to retrieve them. In view of this time cost to Families SA, the Commission ultimately decided to request log sheets only for the 20 notifications assessed as NOCs. The request identified the log sheets by case number. Families SA still took a number of weeks to produce them.

Two of the log sheets contained significant detail that was not entered on C3MS. A log sheet concerning a domestic violence incident included the words ‘drunken rampage’, ‘yelling, banging door’ and ‘scared’. Another log sheet concerning chronic neglect recorded that the mother tells the child to ‘fuck off’ and the grandparents smoke when with the child in a poorly ventilated house. As these details were omitted from C3MS, they were essentially lost to the system.

Notifications should not be recorded on a paper log sheet. The Call Centre should implement an electronic log sheet to permit the ready transfer of data into C3MS. The content of an electronic log sheet should be searchable. Potentially, an electronic log sheet could automatically pre-populate the C3MS intake record.

The Commission heard evidence that C3MS has a propensity to crash, frustrating efforts to input data (discussed further below). Therefore, an electronic log sheet must be implemented in a way that isolates the entry of data while the notification is being received, before it is uploaded to C3MS.

AVAILABILITY OF NOC INFORMATION

Families SA is considering reducing the recording requirements for notifications assessed as NOCs because they take considerable time to enter on C3MS. The options being considered include creating a brief intake page for NOCs or allowing them to be entered as a ‘note’ on C3MS.44

It is understandable that the Agency would like to reduce the time taken to record matters that are viewed as only the concern of the notifier. However, given that some NOC matters should be screened in for a response and others would be important to build a more complete picture of the family, it is vital that any changes to recording requirements for NOC matters ensure the information received remains readily accessible and searchable. In particular, there must be a continuing record of family relationships to allow a complete record of a family’s child protection history to be retrieved.

ENCOURAGING HIGH-QUALITY ASSESSMENTS

PROPER USE OF THE DECISION-MAKING TOOLS

Families SA’s Care and Protection Assessment Framework helps the Agency’s practitioners to assess ‘the needs of children, their families and carers throughout different stages of contact with Families SA’, including at the point of notification.45 The framework encourages practitioners to consider principles of assessment, theoretical perspectives on child wellbeing, and child, parent and family domains. These are offered not as a checklist, but as themes to consider and as a ‘consistent method of gathering, organising and interpreting information to better understand a child and their world’.46

Families SA policy describes the relationship between structured tools, such as screening and response priority tools (the decision-making tools), and professional assessment:

The Assessment Framework provides the professional assessment that is complemented by the use of structured tools. The Assessment Framework is grounded in social work theory and practice and guides workers to prepare the narrative required for thorough assessment. Professional social work assessment encompasses the ability to engage in reflective analysis, interpret and integrate complexities and present sound rationale. The Structured Decision Making tools assist workers to make critical decisions with increased validity, reliability and consistency and importantly to target scarce resources to those children and families at highest risk.47

While the tools support consistent decision making, they are not intended to replace professional judgement.48 Interpreting whether a notification amounts, for example, to a significant risk of serious harm clearly involves an element of subjectivity and requires professional judgement.49
There are potential drawbacks to using structured tools in decision making. Practitioners may apply the tools mechanistically, confining their assessment to the factors listed in the tools and disregarding the child’s circumstances beyond those factors. Focusing too much on the tool may also result in insufficient attention being paid to the ‘thoughts, feelings and words of children’.50

There can be a significant gap between organisational policy and practice. Policy may emphasise the need for professional judgement in conjunction with decision-making tools, yet practitioners, particularly those with less experience, may be reluctant to look beyond the tool. Consequently, if not properly implemented, tools may impair professional judgement.51

These criticisms apply to the use of the decision-making tools in the Families SA Call Centre. Some staff are ‘overly reliant’ on the tools, rather than using ‘their own skills, experience and knowledge base to make assessments’.52 This leads to decisions which are potentially dangerous to children.

In addition to its Intake review, the Commission also reviewed a random sample of 60 C3MS child protection files to gain an insight into Families SA’s usual case practice (see methodology in Appendix C). Across the two reviews, the Commission observed that the decision-making tools did not seem to promote good or consistent decision making in the Call Centre. The tools appeared to be used in a mechanical way, without sufficient recognition of the psychological, developmental and behavioural effects of traumatic, unsafe and chaotic environments on children. There was little evidence of the integration of all information concerning a child. Instead, the tools isolated circumstances into discrete parcels.

There is little room for Call Centre practitioners to exercise professional judgement that is in variance with the decision-making tools. Practitioners apply a ‘mandatory override’ to increase the response priority rating to Tier 1 where (a) the carer has avoided a previous Tier 1 or 2 investigation and is likely to avoid further investigation; or (b) the carer has previously caused death or serious injury to any child due to abuse or neglect.53 Practitioners are permitted to apply a ‘discretionary override’ to increase or decrease the tier rating, but only where ‘unique circumstances’ in the allegations ‘are not captured within … the decision trees’. The practitioner must document the rationale and seek approval from a supervisor or senior practitioner. Importantly, discretionary overrides ‘must not be used simply because the [practitioner] does not agree with the Families SA policy thresholds for tier ratings articulated in the decision trees’.54

While this policy reflects a desire to promote consistent, high-quality decision making, it gives the tools a primacy they do not deserve. It constrains professional judgement in a way that makes it harder for practitioners to keep a clear focus on the needs of children. The limited scope for discretionary override appears inconsistent with the policy sitting around the tools.

Rather than focusing on process and prescription, it is better to invest in highly trained, skilled practitioners, who are supported and supervised to make high quality professional judgements.55 This focus on clinical practice, rather than process, will give practitioners greater confidence to use the decision-making tools as a support, not a replacement, for professional judgement. In turn, practitioners and their supervisors will develop a clearer understanding of the circumstances in which the tools should be overridden to ensure the safety of a child.

**INDUCTION AND ONGOING TRAINING**

It is crucial that Call Centre staff are properly trained and supported to broaden their professional knowledge and assessment skills. Currently, new practitioners receive training in a range of areas, such as answering telephone calls, uploading information on to C3MS, and using the screening and response priority tools. Practitioners start by processing eCARL notifications, before progressing to answering telephone calls. A senior practitioner sits alongside practitioners during their first few calls. This training process takes about two weeks.56

Families SA recently revised its induction program for all new staff.57 However, it still lacks a specific induction package for Call Centre staff.58 This is compounded by the fact that the Call Centre’s policies and procedures need to be revised urgently. An internal review in 2012 observed:

> [The Call Centre’s] extensive soft copy documentation, including the CARL and Crisis Care Manuals of Practice, is significantly out of date and in need of urgent review. Most of the content in these documents is outdated and in some cases key information is missing.59

Four years on, these documents have still not been revised. Staff are still expected to have regard to a large number of overlapping, inconsistent and out-of-date documents. For example, the Call Centre’s Manual of Practice makes no reference to the response priority tool, a critical document when assessing notifications. Similarly, none of the documents references Solution Based Casework™, the practice framework which Families SA implemented in 2014.

The result is that the reader would have little confidence that the principles contained in any one document actually govern practice in the Call Centre. This is likely
to promote confusion and disparate practice between individual practitioners and teams. The Commission shares the lack of confidence.

Call Centre staff have access to fortnightly workplace learning on topics such as infant mental health, infant bruising, sexualised behaviours and homelessness. However, as outlined in Chapter 6, workplace learning in Families SA remains an area of ongoing concern. There is a need to review the induction and ongoing training offered to Call Centre practitioners to ensure it meets their specific needs. A particular focus should be on supporting high-quality assessments and the proper use of the decision-making tools.

THE NEED FOR EXPERIENCED STAFF

According to the Manual of Practice:

The information [Call Centre practitioners] need to get from the caller is not just confined to any particular incident that is being reported, but must include any other information known about the family. CARL workers need to give sufficient time to a caller to ensure that a full and proper assessment can be made. The quality of a child protection assessment is the basis upon which every other intake decision rests and therefore must be given priority in terms of time and skill.

Good assessments in the Call Centre depend on skilled practitioners eliciting the right information from notifiers. This involves asking useful contextual questions to explore and tease out the scenario. In gathering information, practitioners need to respond sensitively to notifiers who may be distressed about the situations they are describing. They also need theoretical learning and practical experience to recognise information that suggests a family is in need of support or a child is at risk of harm. Options the notifier may have to support the family need to be explored and consideration given not only to the particular incident being reported, but also a child’s broader experiences of care.

This all needs to be achieved over the telephone, a medium that makes establishing rapport more challenging.

It takes time to develop the expertise required to make well-rounded assessments. A Families SA executive director told the Commission that in her view new practitioners take three to five years to develop this experience. In the 1980s, practitioners required seven years’ experience in child protection field work before working in the Call Centre.

The Layton Review emphasised that the Call Centre was employing practitioners ‘with less experience than is desirable to service a specialised and critical intake entry point to the child protection pathway’. It recommended that all practitioners receiving calls have ‘at least two years’ field experience in child protection with an optimal level of experience being five years or more’.64

In theory, Families SA recognises this principle:

Research has indicated that it is of benefit for staff at the Call Centre to be the most experienced workers, those workers who have an established knowledge base, well developed social work skills and practice experience.

As discussed later in this chapter, a recent proposal to trial call agents in the Call Centre would entrench the use of inexperienced and untrained workers.

The primary entry point to the child protection system is so much more than simply a call centre. It is clear that to collectively describe the Child Abuse Report Line and Crisis Care service as a call centre is misleading and has the potential to devalue and de-skill the work undertaken by the practitioners. It is in fact an intake, assessment and triage centre. It would be appropriate to rename the Call Centre to reflect this and ensure its significant role in the child protection system is not misunderstood or underestimated.

Practitioners receiving calls and making assessments in the Call Centre must hold degree-level tertiary qualifications relevant to working in child protection. Generally, this will be a qualification in social work. They should have at least three years’ field experience in child protection work, with an optimal level of experience being five years or more.

While there is value in having a stable workforce that is experienced in this specialist area, a mixture of experienced staff is required across the Agency. Regularly rotating staff through the Call Centre would ensure that practitioners remain familiar with fieldwork. Three to five year rotations would serve both objectives.

THE NEED FOR ADEQUATE TIME

Quality assessments also require time. Call Centre practitioners need enough time to:

• elicit all relevant information from the caller;
• review the child’s and the family’s child protection history, as recorded on C3MS;
• consider the information and complete the decision-making tools as part of their assessment; and
• consult with colleagues (if required) and, in the case of Aboriginal or Torres Strait Islander children, consult with Aboriginal family practitioners or principal Aboriginal consultants.
If any stage is rushed, the ultimate assessment and response may be flawed, jeopardising the outcomes for the child, who is the centre of the concern.

A Families SA assistant director told the Commission:

\[ \text{I would rather [Call Centre practitioners] took their time to get the information properly the first time round, and if that takes a little bit longer, so be it. I would rather that than having the wrong information recorded, and then a wrong assessment, wrong decision, wrong intervention, we’re stuffed.} \]

The Commission agrees with this sentiment.

Poor systems can also affect efficiency when practitioners are assessing information. In 2009, the Call Centre started using C3MS, which replaced the former Client Information System (CIS). In 2010, Families SA undertook a further time and motion study that compared the productivity of Call Centre staff using CIS with C3MS. It found that it took staff between 7 per cent and 26 per cent longer to perform a variety of tasks using C3MS.

In July 2012, an internal review of the Call Centre’s operations concluded that the findings of the 2012 time and motion study:

\[ \text{provide strong evidence in support of staff feedback that C3MS limitations are a significant cause of inefficiency at [the Call Centre] and that a disproportionate percentage of social workers’ time is spent on system processes that do not add value to the delivery of child protection services.} \]

Since then, Families SA has taken steps to improve the functionality of C3MS. For example, it has developed a summary history view, which makes it easier to access an overview of a child's history of notifications.

The shortcomings of C3MS and the challenges it presents for practitioners are outlined in Chapter 5.

A business case was developed for the Call Centre as part of the Redesign of Families SA operations that occurred in 2013. It provided a rationale for the proposed remodelling of the Call Centre. The business case calculated that although Call Centre practitioners should be able process an average of 9.5 notifications per day, they were only processing four to five. This is based on an average talk time from 2012/13 plus an average time to record a notification on C3MS involving two children who already existed on the system (based on figures from the 2010 time and motion study). Overall, this gave an average of 38 minutes, 7 seconds, to receive and record a notification. The 9.5 notifications figure was achieved by applying an efficiency rate of 80 per cent to the time. The business case argued that enhancements to C3MS since 2010 mean this benchmark is likely to be a significant overestimate of the time it takes to process notifications.

There are problems with this benchmark. First, it does not allow practitioners any time to consult with senior colleagues, Aboriginal family practitioners or principal Aboriginal consultants. Second, it draws exclusively on the 2010 time and motion study, with no reference to the more recent 2012 study. While both studies found that tasks took longer on C3MS than CIS, the 2012 study showed C3MS to have a greater effect on processing time. This study found it took an average of 60.8 minutes to record a new NOC in CIS, but 40 minutes in C3MS.
to process a notification, including 14 minutes talk time.\textsuperscript{86} This would have produced a much lower benchmark of 5.9 notifications per practitioner per day (also assuming practitioner efficiency of 80 per cent). The evidence before the Commission is that Families SA simply preferred the 2010 study and based its benchmark on that.\textsuperscript{84}

The business case does not contain any analysis of the optimal time a practitioner should spend, for example, on the telephone with a notifier. It identifies that the average talk time increased by 6.9 per cent from 2010 to 2013, but does not discuss whether this is an effective use of time. It mentions that the Diversion Assessment Response Team\textsuperscript{81} and Yaitya Tirramangkotti\textsuperscript{82} talked longer than other teams, without acknowledging the specific duties of these teams might require more talk time. It notes that a call centre in Victoria that also received child protection notifications had an average talk time of about 30 to 45 minutes, without reflecting on whether this produced better assessments or saved time in other areas, such as assessment of the notification.\textsuperscript{83}

The work of Call Centre staff is not suited to an inflexible benchmark. The time to process a notification varies markedly depending upon the complexity of concerns, the ability of the notifier to marshal his or her thoughts, the number of children involved and the extent of relevant child protection history held by the agency. Notifiers already engaged in supporting the family may require particular support and guidance. Some cases require extensive consultation with senior colleagues and Aboriginal family practitioners and/or principal Aboriginal consultants.

Practitioners must spend as much time as is necessary to gather enough useful information to undertake a high-quality assessment about the needs of a child. Of course, in the face of rising demand on the Call Centre’s services, practitioners must spend no more time than is necessary. However, an inflexible benchmark, particularly one based on flawed calculations, will focus practitioners on the quantity of work at the expense of quality.

Poor productivity of particular practitioners should be addressed through supervision and performance management. The case reading process discussed later in this chapter, for example, can assist in addressing both the quality and quantity of assessments, where this is required.

Families SA has identified and scheduled improvements to C3MS that aim to improve its usability.\textsuperscript{84} These enhancements should be implemented as a priority. System slowness must be addressed through the progressive upgrading of infrastructure to accommodate the growing numbers of records.

**QUALITY ASSURANCE AND SUPERVISION**

Because every child in South Australia is equally entitled to be safe from harm and cared for in a way that allows them to reach their full potential, it is important that the Agency is consistent in its assessment of notifications. The Call Centre needs quality assurance processes that promote such consistent decision making among individual practitioners and across teams.

Until early 2015, the senior practitioner in each team reviewed every notification and assessment before it was finalised.\textsuperscript{87} While this provided a level of quality assurance, it did little to promote consistency among senior practitioners and between teams.

Consistent with the findings of its own reviews, the Commission heard from an experienced Call Centre practitioner that the screening and response priority tools are applied differently across the Call Centre, which creates inconsistency of screening decisions between teams.\textsuperscript{88}

It has been recognised that it is time consuming and inefficient to review every notification.\textsuperscript{89} The need to review every notification decision, particularly for experienced staff who generally produce high quality intakes, has been questioned. The Call Centre has now shifted to the practice of senior practitioners reviewing intakes more randomly, but paying particular attention to intakes by less experienced staff.\textsuperscript{90}

Case reading involves the monthly review of a small, random sample of the work of each practitioner, senior practitioner and supervisor against a specific set of criteria. The process monitors and evaluates assessment practice within and across teams, and helps supervisors and senior practitioners to understand the strengths and needs of practitioners in their teams and to promote a ‘culture of reflection, learning and continuous improvement’.\textsuperscript{91} The aim is to ensure that practitioners use the assessment tools to structure and guide their professional judgement, rather than as tick-the-box exercises.\textsuperscript{92}

In addition to quality assurance, case reading is designed to inform clinical supervision, which is a critical component of effective social work practice.\textsuperscript{93}

The creators of the screening and response priority tools regard case reading as integral to their use.\textsuperscript{94} In May 2013, the Families SA Executive approved the implementation of a case reading tool and practice guide in the Call Centre.\textsuperscript{95} Despite this, they have not yet been implemented. As at November 2015, the intention of Families SA was to review and consider case reading as part of developing a new quality assurance framework for the Call Centre.\textsuperscript{96}
While case reading is not the only method of quality assurance, it is supported by the developers of the screening and response priority tools and its implementation was endorsed by the Families SA Executive. Case reading would help ensure that each child who comes into contact with the child protection system through the Call Centre receives a consistent response. It would also support staff learning through more effective clinical supervision. The Commission considers that it should be implemented.

PROBLEMS WITH THE DECISION-MAKING TOOLS

NEGLECT, CUMULATIVE HARM AND SOCIAL ISOLATION

The Call Centre decision-making tools give insufficient weight to issues of neglect, emotional abuse, cumulative harm and social isolation. This potentially contributes to an inflated or overly rigid threshold for intervention.

Abuse and neglect cannot be viewed as isolated events in a child’s life. A single incident, viewed in isolation, may not be extreme or significant. There is growing awareness of the effect of cumulative harm, being chronic incidents of maltreatment over a prolonged period that affect a child’s sense of safety, stability and wellbeing:

The unrelenting daily impact of multiple adverse circumstances and events on the child can be profound and exponential. The exponential nature of chronic maltreatment means that children who have experienced maltreatment in the past may be more vulnerable to subsequent incidents of maltreatment than children who have not been maltreated.100

Although it may be less visible, neglect has profoundly damaging consequences for child development, including impoverished social relationships, attachment and emotional difficulties, language, communication and cognitive developmental delays, impaired neurological development, poor physical health and delayed physical development, and even death or serious injury through poor supervision, malnutrition, dehydration, exposure to infection and medical neglect.101 Indeed, it is potentially even more damaging than other forms of maltreatment, such as physical or sexual abuse.

Neglect also indicates that other forms of maltreatment may be present. There is growing evidence that experiences of abuse or neglect seldom occur in isolation, and that the majority of individuals with a history of maltreatment report exposure to two or more subtypes.102 A child who experiences neglect is also likely to have experienced at least one other form of maltreatment, such as sexual, physical or emotional abuse.

The Commission observed in its review of a random sample of 60 C3MS child protection files that Call Centre staff applied an extremely high threshold for responding to neglect cases (see methodology of the Usual Practice review in Appendix C). There was apparent acceptance of chronic neglect, in particular, as a regrettable fact of life for many children.

The language of the screening and response priority tools requires practitioners to look for ‘extreme’, ‘serious’, ‘significant’, ‘immediate’ or ‘urgent’ circumstances and for entrenched patterns of behaviour. For example, the screening tool defines neglect as:

The child’s basic necessities of life are repeatedly unmet by his/her caregiver to the extent that the child is not receiving the care and supervision necessary to protect him/her from harm, the child suffered physical injury or illness or there is significant risk of serious harm to the child’s well-being and development due to neglect [emphasis added].103

To satisfy one of the screening-in grounds for neglect, the practitioner must also identify factors such as ‘extreme isolation’, ‘significant health or behavioural issues’ and ‘significant lack of parenting skills’.104 Families SA has accepted that the assessment tools need to be revised to better deal with cumulative harm and neglect.105

The tools also give insufficient weight to social isolation, including a lack of engagement with the community or services. For example, the key question in the response priority tool for children under the age of five years experiencing neglect is: ‘Is there a severe condition or pattern of caregiver behaviour that presents significant risk of serious neglect?’106 Only if answered ‘yes’ will the notification be prioritised as a Tier 2 intake.

The requirement for a pattern of behaviour is problematic in cases of very young or socially isolated children. These children are potentially vulnerable because they are invisible to the outside world. Yet they present on C3MS as having few child protection notifications and, as a result, are less likely to receive a response from Families SA.107 Without critical analysis, children most at risk because they are invisible will continue to be passed over because of the absence of a pattern of caregiver behaviour.

In some cases, social isolation is a significant risk factor. A review of United Kingdom child protection cases in which children were killed or seriously injured identified ‘closure’ in more than half the cases examined. This expression refers to episodes when the family deliberately shut itself away from contact with the outside world, including refusing to open the front door, not attending appointments, and keeping children away from school or other services.108
The screening and response priority tools do not encourage practitioners to look beyond the immediate safety concern. For example, if a notifier reports that a child is living in squalor, the tools focus on the symptom (the state of the house), rather than the cause (why the parents are unable to keep the house in a habitable condition) and what effect that underlying cause might be having on the child.

Volume 2, Case study 1: James, describes the circumstances of a child who was removed from his parents when he was four years old. He was found by police, locked in a filthy bedroom, severely malnourished and dehydrated. He had been there for 12 days and fed very little food, on plates slid under the door. He was within days of death.

Eighteen months before his removal, Families SA was notified that police and a support agency had attended his home and found it filthy and uninhabitable. The mother was reported to have poor mental health. The notification was screened in, but only as a Tier 3 intake. The Call Centre practitioner did not regard the available evidence as a ‘severe’ condition or a ‘pattern of caregiver behaviour’. Families SA responded to the notification by writing a letter to the parents inviting them to attend a meeting. Unsurprisingly, there was never any response to the letter.

The assessment tools did not encourage the practitioner to ask important questions, such as, ‘If this family cannot keep the house in a hygienic condition, do they have the capacity to safely parent a small child?’ or ‘What is the cause of the family living like this and what impact might that have on the child?’.

The assessment tools should reinforce and support good professional judgement. Currently, they send the wrong message concerning neglect, cumulative harm and isolation. The tools need to be reworked to instil good practice. Call Centre practitioners will need intentional training and supervision to reinforce the need to respond proactively in these areas.

A REVIEW OF TIER 3 ASSESSMENTS

Families SA describes Tier 3 intakes as involving ‘a low risk of further harm or low level care concerns’, yet some Tier 3 matters involve serious concerns that require prompt assessment. The Commission’s Intake review included 20 Tier 3 notifications. Examples of those notifications follow:

• A mother chased her 12-year-old son outside the house, struck him and called him a ‘lazy cunt’. When her seven-year-old son tried to intervene, she pushed him into the fence and threatened to choke him. The parents argued and the children felt distressed and unsafe. The parents had a long history of previous notifications, including exposing the children to domestic violence.

• Three children, aged seven, 12 and 14 years, lived with their mother, who suffered from mental illness and heard voices. When police attended, the mother exhibited paranoia, reported not having slept for three nights, and started screaming at imaginary people. The mother kept the children home from school. The children had previously been removed from the mother’s care due to domestic violence, neglect and her drug use.

• The parents were heavy drug users who neglected their 15-year-old child in various ways, including not providing enough food, allowing poor school attendance and not providing lunch when she did attend school. The parents were aggressive towards her and she was visibly fearful of them. She spent a lot of time in her room worried about her future. The parents had a long child protection history, including physical abuse, exposing children to domestic violence, drug use and attempted suicide.

• Three children, aged six, nine and 16 years, witnessed a community fight, possibly concerning drugs. The mother removed the children from the house due to domestic violence. The nine-year-old child attended school in dirty, blood-stained clothes, stating that she was there to be safe and to escape fighting. There were seven previous notifications, which included the children being exposed to sexual activity in overcrowded housing and the father threatening suicide in their presence.

The Commission was guided in its review by both professional judgement and the screening and response priority tools. The review concluded that 13 of the 20 Tier 3 intakes, including the four examples above, required assessment within about one week and should have been assessed as Tier 2 intakes. The Commission considered that a further two of the 20 cases required immediate assessment and should have been screened in as Tier 1 intakes. The remaining five required assessment, but less urgently than within one week.

Because of the very small sample size, the Commission is cautious about extrapolating these findings. However, the results highlight that, even when children at significant risk of harm are screened in for a response, the priority given to them may not reflect their needs or level of vulnerability.
IMPROVING TOOLS AND TRAINING TO BETTER RESPOND TO CHILDREN

The results of the Intake review’s assessment of Tier 3 ratings reinforce the need for Families SA to review the response priority tool to encourage better responses for children at risk. Families SA also needs to invest in improved training, supervision and quality assurance to support Call Centre practitioners to make appropriate, consistent decisions.

There is a fundamental connection between the decision-making tools and how Families SA responds to a child. Chapter 9 describes the poor responses by Families SA to the vast majority of Tier 2 and Tier 3 intakes. Any review of the response priority tool must be accompanied by appropriate policy and resourcing to ensure that all screened-in notifications receive an effective response.

GIVING WEIGHT TO A NOTIFIER’S EXPERIENCE OR EXPERTISE

In 2014/15, the Call Centre received 57,812 notifications. Table 7.6 and Figure 7.1 show the percentage of notifications made by different groups of notifiers from 2011/12 to 2014/15. Three groups—police, education (school or pre-school) and health—provided 62 per cent of notifications. A further 12 per cent were drawn from non-government agencies and 6 per cent from other government agencies. Together, these sources accounted for about 80 per cent of notifications.

Table 7.6: Notifications by notifier group, 2011/12 to 2014/15

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>PERCENTAGE OF TOTAL NOTIFICATIONS</th>
<th>2012/13</th>
<th>PERCENTAGE OF TOTAL NOTIFICATIONS</th>
<th>2013/14</th>
<th>PERCENTAGE OF TOTAL NOTIFICATIONS</th>
<th>2014/15</th>
<th>PERCENTAGE OF TOTAL NOTIFICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police</td>
<td>8713</td>
<td>22%</td>
<td>9387</td>
<td>22%</td>
<td>10,468</td>
<td>21%</td>
<td>15,568</td>
<td>27%</td>
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<tr>
<td>School or preschool</td>
<td>8357</td>
<td>21%</td>
<td>9695</td>
<td>22%</td>
<td>11,967</td>
<td>25%</td>
<td>12,359</td>
<td>21%</td>
</tr>
<tr>
<td>Health</td>
<td>6211</td>
<td>15%</td>
<td>6727</td>
<td>15%</td>
<td>7614</td>
<td>16%</td>
<td>8059</td>
<td>14%</td>
</tr>
<tr>
<td>Non-government agency</td>
<td>4676</td>
<td>12%</td>
<td>5643</td>
<td>13%</td>
<td>6506</td>
<td>13%</td>
<td>6753</td>
<td>12%</td>
</tr>
<tr>
<td>Family/friend/neighbour</td>
<td>6185</td>
<td>15%</td>
<td>6109</td>
<td>14%</td>
<td>4984</td>
<td>10%</td>
<td>5794</td>
<td>10%</td>
</tr>
<tr>
<td>All other government</td>
<td>1631</td>
<td>4%</td>
<td>1524</td>
<td>4%</td>
<td>1899</td>
<td>4%</td>
<td>3654</td>
<td>6%</td>
</tr>
<tr>
<td>Unknown/other</td>
<td>3227</td>
<td>8%</td>
<td>2891</td>
<td>7%</td>
<td>3364</td>
<td>7%</td>
<td>3213</td>
<td>6%</td>
</tr>
<tr>
<td>Child care</td>
<td>547</td>
<td>1%</td>
<td>609</td>
<td>1%</td>
<td>913</td>
<td>2%</td>
<td>1209</td>
<td>2%</td>
</tr>
<tr>
<td>Families SA personnel</td>
<td>896</td>
<td>2%</td>
<td>894</td>
<td>2%</td>
<td>1074</td>
<td>2%</td>
<td>1173</td>
<td>2%</td>
</tr>
<tr>
<td>Self-report (child)</td>
<td>64</td>
<td>&lt;1%</td>
<td>60</td>
<td>&lt;1%</td>
<td>48</td>
<td>&lt;1%</td>
<td>28</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Total</td>
<td>40,507</td>
<td>100%</td>
<td>43,539</td>
<td>100%</td>
<td>48,837</td>
<td>100%</td>
<td>57,810</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Data provided by Families SA.

Note: ‘Unknown/other’ includes legal professionals, ministers of religion, other religious/spiritual personnel, sport or recreational personnel, family law system notifiers, and notifiers marked as ‘anonymous’ or ‘unknown’ or the notifier category left blank. ‘All other government’ includes allied health, Centrelink, Corrections, Disability SA, drug/alcohol workers, Housing SA, interstate counterparts, psychologists, social welfare professionals and social workers. ‘Non-government agency’ includes accommodation/shelter workers, drug/alcohol workers, family support workers, psychologists, rape and sexual assault workers, social welfare professionals, social workers and volunteers.
### Table 7.7: Proportion of notifications screened in by notifier group 2011/12 to 2014/15

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NUMBER OF NOTIFICATIONS SCREENED IN</td>
<td>PERCENTAGE SCREENED IN OF GROUP’S TOTAL NOTIFICATIONS</td>
<td>NUMBER OF NOTIFICATIONS SCREENED IN</td>
<td>PERCENTAGE SCREENED IN OF GROUP’S TOTAL NOTIFICATIONS</td>
</tr>
<tr>
<td>Police</td>
<td>4167</td>
<td>48%</td>
<td>4436</td>
<td>47%</td>
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<tr>
<td>School or preschool</td>
<td>2892</td>
<td>35%</td>
<td>2928</td>
<td>30%</td>
</tr>
<tr>
<td>Health</td>
<td>3025</td>
<td>49%</td>
<td>2877</td>
<td>43%</td>
</tr>
<tr>
<td>Non-government agency</td>
<td>1912</td>
<td>41%</td>
<td>1946</td>
<td>34%</td>
</tr>
<tr>
<td>Family/friend/neighbour</td>
<td>2573</td>
<td>42%</td>
<td>2338</td>
<td>38%</td>
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<tr>
<td>All other government</td>
<td>742</td>
<td>45%</td>
<td>679</td>
<td>45%</td>
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<tr>
<td>Unknown/other</td>
<td>1182</td>
<td>37%</td>
<td>979</td>
<td>34%</td>
</tr>
<tr>
<td>Child care</td>
<td>218</td>
<td>40%</td>
<td>250</td>
<td>41%</td>
</tr>
<tr>
<td>Families SA personnel</td>
<td>563</td>
<td>63%</td>
<td>499</td>
<td>56%</td>
</tr>
<tr>
<td>Self-report (child)</td>
<td>30</td>
<td>47%</td>
<td>26</td>
<td>43%</td>
</tr>
<tr>
<td>Total</td>
<td>17,304</td>
<td>43%</td>
<td>16,958</td>
<td>39%</td>
</tr>
</tbody>
</table>

Source: Data provided by Families SA.

Note: See note for Table 7.6.

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**Figure 7.1: Notifications by notifier group in 2014/15**

Source: Data provided by Families SA.

Note: See note for Table 7.6.
Table 7.7 and Figure 7.2 show the percentage of notifications from each notifier group that were screened-in.

The proportion of screened-in notifications in recent years has fallen markedly across all major notifier groups. There are a number of possible explanations for this shift, including:

- notifiers generally have become more risk-averse;
- the use of eCARL has increased, causing notification quality to decline (as discussed below); and
- the screening threshold has increased over time.

Whatever the explanation, the fact remains that many of these notifiers have regular contact with the child, giving them the opportunity to observe the effect their concerns are having. They will often know considerably more about the child than the practitioner assessing the notification. Many also have experience and qualifications in areas such as education, health or disability services, making them well placed to assess the risks facing the child. For instance, a teacher who has had the child in class all year, or a doctor who has seen worrying or unexplained injuries, should be listened to very carefully.

Yet Families SA policy and its decision-making tools do not encourage practitioners to place any weight on the notifier’s experience, expertise or contact with the child. The Commission heard evidence that this is also the case in practice. For example, notifications from experienced forensic paediatricians are treated like those from any other notifier.104

While the status of a notifier is not determinative, it is a factor that should be considered. The Agency’s policy should expressly require that assessments give weight to the relevant experience and expertise of notifiers. Particular attention should be given to the extent and nature of contact that the notifier has had with the child concerned.

THE NEED FOR TIMELY FORENSIC MEDICAL ASSESSMENTS

Children who present with physical injuries frequently need a forensic medical assessment to determine the cause of their injuries. If the assessment does not occur promptly, optimally within 24 hours, then crucial evidence may be lost, which could jeopardise future prosecutions or assessments of child safety. Importantly, if parents refuse to consent to a forensic medical assessment, it cannot proceed without the intervention of Families SA.105

Families SA only employs a Tier 1 rating if a child is in immediate danger. If a child has sustained physical trauma and is admitted to hospital, the Call Centre will generally consider that the child is conditionally safe as he or she is in hospital and therefore not in immediate danger. The case will receive a Tier 2 rating and a
response would be expected within three to 10 days, depending on the circumstances. In that time, the opportunity to gather evidence may be lost.

Moreover, unlike Tier 1 intakes, Families SA policy permits Tier 2 intakes to be Closed No Action by Assessment and Support teams. This means the injured child may receive no response at all.

The Commission was given a number of examples where evidence of children’s physical trauma was lost because Families SA did not respond soon enough for a forensic medical assessment to occur. The Commission heard that the Women’s and Children’s Hospital Child Protection Services has advocated for a long time, without success, for Families SA to revise the tier ratings with respect to the bruising or injury of children, particularly babies.

If parents will not consent to a child’s forensic medical assessment after hours, the responsibility falls to Families SA’s Crisis Care service to intervene. However this service principally responds only to Tier 1 cases. Tier 2 intakes may receive a response where there is an ‘absolute need’ for a child to be removed from their parent. A Families SA assistant director was asked if this meant that a child presenting with injuries on the weekend might only receive a response the following Monday morning. She responded, ‘I would hope not’, adding that the Call Centre would hold a strategy discussion with the relevant Child Protection Services over the weekend, ‘if it had capacity’. This less than definitive response gives the Commission little confidence.

The Call Centre, in particular its Crisis Care service, must be adequately resourced so that forensic medical assessments are not dependent on Call Centre capacity. The response priority tool must be reviewed to ensure due weight is given to the need to conduct timely forensic medical assessments, and Call Centre practitioners must be trained in the importance of these assessments occurring without delay.

**CALL CENTRE WAITING TIMES**

Dismay regarding the length of time spent waiting to have telephone calls answered by the Call Centre was a prevailing theme across the submissions and evidence of notifiers. As discussed later in this chapter, the eCARL service provides an alternative notification option in some cases, but it cannot be used to report serious, urgent matters or those involving infants under the age of 12 months. In those cases, the telephone service is the only option.

It is difficult to get a true measure of the Call Centre’s waiting times. Families SA provided average waiting time statistics to the Commission. They indicate that across the Call Centre the average waiting time was only 11 minutes, 57 seconds (11:57) in 2014/15. This does not accord with evidence gathered by the Commission from users of the Call Centre. The average, in fact, underestimates the waiting times experienced by most users of the Call Centre, because it gives equal weighting to waiting times on the general, health and non-emergency police lines— which each receive many thousands of calls a year and which experience relatively long waiting times—as to the emergency line, which receives relatively few calls and is answered almost immediately.

Table 7.8 shows the increasing average waiting times on the Call Centre general, health and police lines during the past four years.

<table>
<thead>
<tr>
<th>Table 7.8: Average waiting times (minutes, seconds) of the general, health and police telephone lines, 2011/12 to 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2011/12</strong></td>
</tr>
<tr>
<td>General&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>General after-hours&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Health&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Police&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup> Prior to 2014/15, this category included telephone calls received during business hours from the general public, police, education and health sectors and emergency calls. From 2014/15, this category included calls received at all hours from the general public and education sector, but excluded calls from the police and health sectors and emergency calls.

<sup>b</sup> An after-hours line that received telephone calls from the general public and police, education and health sectors, including emergency calls.

<sup>c</sup> From 2014/15, Families SA separated waiting times for health and police notifiers from all other notifiers. These categories exclude emergency calls.

Source: Data provided by Families SA.

The wait times prior to 2014/15 are understated somewhat because they include calls to the emergency line which are separately reported for the first time in 2014/15. Even so, the steady rise in average waiting times can be observed.

Even the 2014/15 figures represent averages across the year. At particular times of day, the Call Centre experiences much higher demand, resulting in correspondingly longer waiting times. For example, while the overall Call Centre average waiting time in 2014/15 was 11:57 between 5.01pm and 9pm, this increased to 26:14, a figure that gives equal weighting to the emergency line.
Table 7.9 shows waiting times are also sensitive to the time of year. January, which covers the school holidays, was the quietest period, with average waiting times of 8:12 for the general line and 8:29 for the health sector. By contrast, in June average waiting times rose to 38:32 for the general line and 44:09 for the health sector.

Maximum waiting times are startling. The longest waiting time in 2014/15 was a call received between 5.01pm and 9pm in November, during which a caller waited three hours, 43 minutes and 40 seconds for the call to be answered. Table 7.10 shows that maximum waiting times have grown considerably longer during the past four financial years.

Table 7.10: Maximum waiting times (hours, minutes, seconds) for the Call Centre, 2011/12 to 2014/15

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>1:24</td>
<td>0:15</td>
<td>0:16</td>
<td>0:17</td>
</tr>
<tr>
<td>Police</td>
<td>0:20</td>
<td>0:00</td>
<td>0:16</td>
<td>0:20</td>
</tr>
<tr>
<td>DART</td>
<td>0:55</td>
<td>11:38</td>
<td>14:37</td>
<td>15:59</td>
</tr>
<tr>
<td>Crisis Care</td>
<td>14:06</td>
<td>18:08</td>
<td>12:19</td>
<td>17:56</td>
</tr>
<tr>
<td>Emergency</td>
<td>N/a</td>
<td>0:17</td>
<td>0:17</td>
<td>0:15</td>
</tr>
</tbody>
</table>

Further, every month between 1 July 2014 and 30 June 2015 had a call that took more than two hours to answer, and there were four months in which a call took more than three hours to answer. While there will always be periods of unexpected demand, this is clearly unacceptable.

Many callers give up waiting. Table 7.11 shows the number of telephone calls to the Call Centre that were attempted, answered and abandoned during the past four financial years.

Table 7.11: Attempted, answered and abandoned telephone calls to the Call Centre, 2011/12 to 2014/15

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total calls attempted</td>
<td>54,528</td>
<td>54,941</td>
<td>52,829</td>
<td>66,983</td>
</tr>
<tr>
<td>Calls abandoned</td>
<td>21,470</td>
<td>22,030</td>
<td>26,727</td>
<td>25,227</td>
</tr>
<tr>
<td>Calls answered (percentage of total)</td>
<td>32,058 (61%)</td>
<td>32,911 (60%)</td>
<td>26,102 (49%)</td>
<td>41,756 (62%)</td>
</tr>
</tbody>
</table>

Source: Data provided by Families SA.
The situation grew dramatically worse in 2013/14, when less than half of attempted calls were answered, before returning to trend in 2014/15, when about 60 per cent of attempted telephone calls to the Call Centre were answered.

Some notifiers try to call several times before their call is answered. This has the potential to inflate the number of abandoned calls recorded in Table 7.11. The Call Centre has no means of determining what proportion of these are repeat calls.

Notifiers are ordinary members of the community, who have their lives to lead. Many are busy professionals, including police, teachers, doctors and nurses, who are satisfying their public, ethical and legal duties by contacting the Call Centre. It is unreasonable and grossly inefficient to expect notifiers to wait such long periods of time.

THE CALL-BACK OPTION

The telephone system used by the Call Centre has a call-back feature. However, Families SA has decided not to activate it. This feature would allow notifiers to telephone the Call Centre and, rather than waiting in a queue, leave their telephone number and receive a call back. The provided call-back number could remain in the queue along with live calls and be dialled automatically when a practitioner is available. It would avoid notifiers having to wait unproductively on the telephone, sometimes for more than two hours, for their call to be answered.

In 2012, Families SA surveyed 1195 notifiers as part of an internal review of the Call Centre’s operations. Of those, 84 per cent said they would like the option of a call back. The most commonly perceived benefit was that it would save notifiers’ time.

The Commission was told that Families SA held concerns that the system could bank more calls than the Call Centre had the capacity to return in a timely fashion. Further, other jurisdictions have found the feature so popular that demand outstrips the ability to return calls.

THE RELEVANCE OF STAFF ROSTERING

Staff rostering has a significant effect on waiting times. At 8 January 2016, the Call Centre had 73.6 full-time equivalent (FTE) positions, with 4.5 FTE vacancies. Practitioners are divided into teams. A day team and a Linking Families team work normal business hours from Monday to Friday. In addition, three shift teams are rostered flexibly across day, afternoon and night shifts to ensure demand does not outstrip the Call Centre’s capacity. However, in cases of extraordinary demand, consideration should be given to the use of overtime, which could include seconding former experienced Call Centre practitioners who are working elsewhere in the Agency, to assist in clearing backlogs.

Following a trial period, the effectiveness of the call-back feature should be reviewed, in particular its effect on waiting times and call abandonment rates, to determine whether its ongoing use is justified.
The Call Centre has a workforce management tool to better respond to call demand. It captures call trends by day, week and year, to enable the centre to predict periods of peak demand based on factors such as school terms, public events and public holidays. In theory, this will more closely match rostering levels to demand.127

In April 2015, Families SA was using the workforce management tool to gather data and hoped to interpret that data to make better use of staff to meet periods of peak demand.128 A year later, the system continued to capture call data, but no changes to the roster had been implemented, although Families SA was consulting staff about possible changes.129

In the medium term, measures outlined in this report may reduce demand on the system, and therefore the Call Centre.

In general, callers should not wait more than 30 minutes to have their call answered and no eCARL notification (discussed later in the chapter) should take longer than 24 hours to be assessed. If the call-back function is activated, then no caller should wait longer than two hours for a return call. The Agency should undertake a thorough review of its staffing levels, rostering and deployment of resources, informed by data from the workforce management tool, to meet this service standard.

THE CRISIS CARE SERVICE

SCOPE OF SERVICES

The Call Centre operates an after-hours Crisis Care service each weekday from 4pm to 9am. It operates 24 hours a day on weekends and public holidays.130

The service has contracted significantly in recent years. As recently as June 2016, information displayed prominently on the South Australian government website stated that the service assisted people in crises as a result of:

- child abuse or neglect;
- children needing foster care or alternative care;
- domestic violence;
- high-risk adolescence behaviour or need;
- parent-child disputes;
- homelessness;
- urgent financial need;
- suicidal behaviour;
- personal trauma; and
- natural disasters, such as floods.

It stated that Crisis Care could offer services including:

- child abuse investigations;
- placement and support to children in Families SA care;
- emergency food and material assistance assessment;
- counselling, information and support; and
- referrals to other agencies.

In fact, Crisis Care no longer provides most of these services. Assistance is predominantly limited to abuse and neglect matters where children require out-of-home care and services for children in out-of-home care. The other services listed are either not provided or are referred to another agency.132

An internal review of the Call Centre in 2012 identified that information on the South Australian Government website was out of date.133 This remains the case. Incorrect information potentially increases the Call Centre’s workload, through people telephoning for services that are no longer provided. The Commission was told that information on Crisis Care available via the internet was being rewritten.134

The Agency needs to review Crisis Care to ensure that it is offering appropriate services. Ongoing, up-to-date information needs to be provided to the public concerning the services that are offered.

STAFFING LEVELS

Due to low average demand overnight, staffing in the Call Centre is reduced to two employees from about midnight until 7am.135

At times, the Crisis Care service requires staff to leave the Call Centre, for example, to remove a child who is in imminent danger, to visit a family home to check on a child’s welfare or to transport a child in care. According to an assistant director, if staff leave the Call Centre at night, they travel in pairs for safety reasons.136 However, the Commission heard evidence that from time to time a practitioner may leave the Call Centre alone, which could be ‘quite risky, depending on what you’re dealing with’.137

Families SA policy states that the Call Centre must never be left unattended. This is because it is the primary means of reporting child abuse or neglect for the entire state. If practitioners need to leave, they are supposed to contact their on-call supervisor, who should either attend the Call Centre personally or arrange for someone else to do so. Staff should wait for the replacement staff member to arrive before leaving.138

Contrary to policy, the Call Centre has been closed twice in the past few years. In late 2013, it was closed for about 90 minutes so that staff could attend a meeting with the then Families SA Deputy Chief Executive,
David Waterford, about proposed reforms to the structure and model of service delivery of Families SA. Calls during this period were placed on hold and, when staff returned, the longest waiting time exceeded three hours.\textsuperscript{139}

It beggars belief that the state’s only child protection Call Centre was closed for an extended period for a staff meeting. Of further concern is the fact that callers were not told the Call Centre was closed, but were left languishing on hold.

In December 2014, the Call Centre closed between about 1am and 2am when the two rostered staff went to a nearby hospital to remove a newborn infant from the care of the child’s parents. Telephone calls continued to queue in their absence.\textsuperscript{140} It is unclear who authorised the closure. However, the assistant director of the Call Centre agreed in hindsight that it should not have been closed.\textsuperscript{141}

The critical point is that the Call Centre is staffed for about seven hours overnight at a level that prevents practitioners from readily performing Crisis Care duties that require travel off-site. While staff can organise replacement practitioners, this involves delay and, in practice, there appears to be some reluctance to do this.\textsuperscript{142}

There is no place for such reluctance. It would be surprising, given the population of greater metropolitan Adelaide, if Call Centre staff were not often required to attend off-site between midnight and 7am to undertake duties such as responding to children at risk of immediate harm, facilitating forensic medical assessments of children, transporting children in care and conducting welfare checks. The Call Centre needs to be resourced to perform these tasks at any hour, while also maintaining a telephone notification service to the state.

This means the Call Centre should have a minimum of three staff rostered on at all times. This would allow two practitioners to attend off-site when required, with the third person remaining to answer telephone calls. Although demand for the telephone service is generally lower at night, there are always eCARL notifications to be assessed. Therefore, a third staff member would always have useful work to do.\textsuperscript{143}

Another option, if Crisis Care staff have to attend off-site, would be for calls to the Call Centre to be diverted to an on-call staff member who has remote access to C3MS. Chapter 5 discusses the need for remote access to C3MS using mobile devices.

### NOTIFYING ELECTRONICALLY THROUGH eCARL

Since July 2013, the eCARL service has allowed all members of the public to report their concerns over the internet. Table 7.12 shows that demand for eCARL has grown quickly and now accounts for about 37 per cent of all notifications.

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total notifications</td>
<td>48,837</td>
<td>57,810</td>
</tr>
<tr>
<td>eCARL notifications</td>
<td>13,355</td>
<td>21,536</td>
</tr>
<tr>
<td>(percentage of total)</td>
<td>(27%)</td>
<td>(37%)</td>
</tr>
</tbody>
</table>

Source: Data provided by Families SA.

In April 2015, the system was receiving between 1900 and 2000 notifications a month.\textsuperscript{144}

In June 2013, the Debelle Inquiry welcomed eCARL being offered to all members of the community as ‘a very effective reform [that] might assist in reducing delays on what is already a very busy, if not overloaded, service’.\textsuperscript{145}

As Table 7.11 and Table 7.12 show, although eCARL has proven popular, it has not reduced demand on the telephone service. Since 2011/12, attempted and answered telephone calls have risen by 23 per cent and 26 per cent respectively, alongside growing demand for eCARL.

Some notifiers also telephone the Call Centre to confirm that their eCARL notification has been received. This may be because the system does not send an automated response to the notifier confirming the notification has been received and its status.\textsuperscript{146}

The Commission was told that eCARL is ‘an excellent example’ of pressure to address the ongoing issue of waiting times exacerbating the problem.\textsuperscript{147} A senior officer in Families SA gave evidence that the launch of eCARL to the public was rushed for reasons unrelated to service need.\textsuperscript{148} As a result, a ‘botched’ version was launched.\textsuperscript{149} Key features were not ready, nor was adequate staffing in place to respond to eCARL notifications. Further, C3MS crashed when practitioners tried to enter data from eCARL.\textsuperscript{150}
DEALING WITH BACKLOGS

Of particular concern were key periods when backlogs developed, causing delays of up to a week to assess eCARL notifications. In response, in April 2015, a dedicated team of eight employees was established to process eCARL notifications. This team processes about half of the 500 eCARL notifications received each week, with the remainder processed by other Call Centre staff during quiet periods.

However, backlogs remain a problem. Table 7.13 shows the peak number of eCARL notifications waiting to be assessed each month from July to December 2015.

Table 7.13: Peak number of eCARL notifications awaiting assessment, July to December 2015

<table>
<thead>
<tr>
<th></th>
<th>JULY</th>
<th>AUG.</th>
<th>SEPT.</th>
<th>OCT.</th>
<th>NOV.</th>
<th>DEC.</th>
</tr>
</thead>
<tbody>
<tr>
<td>eCARL notifications</td>
<td>565</td>
<td>1157</td>
<td>1219</td>
<td>1186</td>
<td>1770</td>
<td>1861</td>
</tr>
</tbody>
</table>

Source: Data provided by Families SA.

As shown in Table 7.14, the maximum amount of time taken to assess eCARL notifications has also steadily risen.

Table 7.14: Maximum time to assess an eCARL notification from time of receipt, July to December 2015

<table>
<thead>
<tr>
<th></th>
<th>JULY</th>
<th>AUG.</th>
<th>SEPT.</th>
<th>OCT.</th>
<th>NOV.</th>
<th>DEC.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days</td>
<td>8</td>
<td>12</td>
<td>17</td>
<td>22</td>
<td>23</td>
<td>36</td>
</tr>
</tbody>
</table>

Source: Data provided by Families SA.

These figures show a system spiralling out of control. The steps taken to respond to the problem have proved to be inadequate, and the backlog has built over time to crisis proportions.

Backlogs cannot be permitted to persist. While the system attempts to prevent the notification of very urgent matters via eCARL, in practice notifiers routinely report matters assessed as Tier 2 intakes, which require a response within five days. If the Call Centre delays processing notifications, then vulnerable children could be left without assistance or intervention for extended periods.

Backlogs must be cleared promptly through staff overtime, including by seconding former experienced Call Centre staff working elsewhere in the Agency. If backlogs persist, additional staff should be employed on an ongoing basis.

THE INAPPROPRIATE USE OF eCARL

Because eCARL notifications are not responded to immediately, Families SA seeks to prevent notifiers using the system for both urgent notifications, which are normally assessed as Tier 1, and those involving infants under 12 months of age, which are normally assessed as Tier 1 or Tier 2 (3 days infant). eCARL directs notifiers to report these matters by telephone. This is a sensible precaution.

However, the system is not foolproof. Sometimes notifiers inappropriately submit notifications via eCARL that are later assessed as Tier 1, by, for example, incorrectly answering directed questions and entering serious allegations in the ‘free text’ boxes.

Table 7.15 compares the annual number of eCARL notifications with the number of eCARL notifications that were ultimately assessed as either Tier 1 or Tier 2 (3 days infant).

Table 7.15: Total eCARL notifications and those assessed as Tier 1 or Tier 2 (3 days infant), 2013/14 and 2014/15

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>eCARL notifications</td>
<td>13,355</td>
<td>21,536</td>
</tr>
<tr>
<td>eCARL notifications assessed as Tier 1 (Percentage of eCARL notifications)</td>
<td>150 (1%)</td>
<td>200 (1%)</td>
</tr>
<tr>
<td>eCARL notifications assessed as Tier 2 (3 days infant) (Percentage of eCARL notifications)</td>
<td>778 (6%)</td>
<td>1522 (7%)</td>
</tr>
</tbody>
</table>

Source: Data provided by Families SA.

In 2014/15, 1722 eCARL notifications, or about 8 per cent of eCARL notifications, were ultimately assessed as either Tier 1 or Tier 2 (3 days infant). This may not entirely be the result of the inappropriate use of eCARL to submit serious and urgent allegations. This is because a notification may comprise information from more than one notifier, including information received separately by telephone and eCARL. A notifier might use eCARL to report a relatively low-level concern at about the same time another notifier uses the telephone service to report more serious, urgent concerns about the same family. Similarly, a teacher might report concerns using eCARL about a school-aged child, independent of concerns reported to the telephone line about an infant sibling. In each case, the combined information may result in an elevated tier rating, even though the notifier may have followed eCARL’s guidelines.
On the evidence available to the Commission, it cannot be determined how many of the eCARL notifications assessed as Tier 1 or Tier 2 (3 days infants) are a result of contemporaneous notifications and how many a result of notifiers inappropriately using eCARL. However, it is unlikely that contemporaneous notifications would account for all 1722 Tier 1 and Tier 2 (3 days infant) notifications in 2014/15.

Despite this uncertainty, the significant and rising number of eCARL notifications that ultimately receive an elevated tier rating is cause for concern. It emphasises the need to process all notifications promptly. It also underscores the need to ensure that only notifiers who are properly trained use the service, as discussed below.

QUALITY OF eCARL NOTIFICATIONS

The Commission has received evidence that eCARL notifications often contain significantly less detail and are of poorer quality than telephone notifications. To offset this, the Call Centre could telephone notifiers for more information, but it generally does not because of time constraints. Table 7.16 shows that a significantly higher proportion of eCARL notifications are assessed as Notifier Only Concerns (NOCs) than for notifications generally. (NOCs are screened out as not requiring a response.) While the Commission has concerns about the use of the NOC classification generally, there appear to be particular challenges related to the quality of eCARL notifications.

Table 7.16: eCARL Notifier Only Concerns (NOCs) as a percentage of total NOCs, 2013/14 and 2014/15

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total eCARL notifications a</td>
<td>13,355</td>
<td>21,536</td>
</tr>
<tr>
<td>eCARL NOCs (percentage of total eCARL notifications)</td>
<td>7678 (57%)</td>
<td>12,856 (60%)</td>
</tr>
<tr>
<td>Total notifications</td>
<td>48,837</td>
<td>57,810</td>
</tr>
<tr>
<td>Total NOCs (percentage of total notifications)</td>
<td>22,048 (44%)</td>
<td>27,965 (48%)</td>
</tr>
</tbody>
</table>

Table 7.16 includes notifications where there was at least one eCARL notifier. In some cases, a notification may be contributed to by more than one notifier. For this reason, ‘total eCARL notifications’ may include notifications where there was both an eCARL notification and a telephone notification.

Source: Data provided by Families SA.

eCARL has a limited role to play in the reporting of child protection concerns and its current high level of use is unhelpful. However, in the face of extended waiting times in the Call Centre, it is understandable why busy professionals might opt to use the internet.

The convenience of eCARL comes at significant cost. The lack of interaction between the notifier and the Call Centre practitioner is a significant drawback. eCARL separates the recording of the notification from its assessment, not unlike the use of call agents (discussed below). Because the practitioner has no opportunity to clarify the notifier’s concerns or elicit further details, there is real potential for miscommunication or inadequate information undermining the assessment.

If the true nature of the concerns is not understood, the notification is much more likely to be assessed as a NOC on the basis that it is vague or contains insufficient information. The risk is that serious concerns may go unheeded.

The lack of interaction also limits the opportunity to use the notification process to strengthen relationships between the Agency and notifiers, whether they are members of the public or employees of government or non-government agencies. Interaction during a telephone notification presents an opportunity to educate and provide feedback to the notifier about the relative severity of the concerns and to explore what assistance the notifier is able to provide to the child or family.

The following measures would help refocus the use of eCARL. First, as discussed below, the Agency is revising mandatory notifier training. The revised training must include specific guidance on the use of eCARL, including the types of matters that it is appropriate to report using eCARL, the level of detail required and the potential drawbacks of eCARL compared to the telephone service.

Second, eCARL’s use should be limited to notifiers who have completed mandatory notification training. The system should prevent other notifiers from using eCARL and direct them instead to the telephone service. It is unrealistic to expect untrained notifiers to know which matters are appropriate to report by eCARL and to provide sufficiently detailed yet targeted accounts without interacting with an experienced Call Centre practitioner.
IDENTIFICATION AND NOTIFICATION

Third, the Agency has proposed introducing a mandated notifier guide at the start of the eCARL application, similar to an interactive guide used in New South Wales. The guide would be based on the screening and response priority tools used by the Call Centre. Giving notifiers access to the same tools that inform assessments would help them decide whether a matter need be reported. This makes it even more important to revise these tools to address the shortcomings identified in this chapter, for example, in relation to neglect and cumulative harm. With these revisions in place, the guide would be likely to foster greater understanding between the Agency and notifiers about assessments made by the Call Centre and, in turn, assist in reducing the number of eCARL notifications screened out because of deficient information.

Fourth, the eCARL system should be upgraded to provide automated electronic feedback to notifiers. Notifiers should be advised when their notification has been received and when their notification will be assessed. This is important so that the notifier is aware when the assessment will be made, and can re-notify immediately if concerns surrounding the child worsen.

Once the notification has been assessed, the notifier should be advised what screening and response priority decisions were made. If the notification is referred to a particular Assessment and Support team, they should be advised of this as well. Where an eCARL notification is screened out, for example, because the concerns are too vague, the notifier must be given brief but specific feedback to this effect, together with an invitation for the notifier to supply further detail by telephone.

Finally, from the perspective of notifiers, eCARL’s primary benefit is that it eliminates waiting on the telephone. By addressing excessive telephone waiting times, including through a call-back service, demand for eCARL should return to more manageable levels.

THE PROPOSAL TO USE CALL AGENTS

As at January 2016, all staff who receive telephone calls or process eCARL notifications were employed in the allied health practitioner (AHP) stream, an employment category that effectively requires staff to hold a social work degree.

In February 2015, a cross-government Executive Change team reviewed the Call Centre and recommended that Families SA trial a dedicated team of call agents to address waiting times. The proposal argued that while the average telephone call occupied only 10 to 12 minutes, ‘inefficiencies’ meant that a Call Centre practitioner could only process one call every 45 minutes. The proposal would separate the function of receiving and recording telephone notifications from their assessment.

Ten call agents would be rostered on between 7am and 7pm each weekday to receive and record telephone notifications. They would be supervised by a supervisor with significant child protection experience and provided with a detailed script to guide their conversations with notifiers. A screening tool and training would help them to identify potential Tier 1 notifications, which they would transfer immediately to a social worker.

The proposal suggested agents could each receive about five telephone calls an hour during peak periods and therefore process up to 300 calls a day and 60,000 notifications a year. The expectation was that these agents would receive and record all telephone notifications, other than Tier 1 notifications. Based only on the information recorded by the agents, qualified practitioners in the Call Centre would then screen the notifications and apply response priority ratings.

There is uncertainty as to the proposed classification of the call agents. One proposal was to employ unqualified, operational services (OPS) stream workers, rather than qualified social workers. Yet a draft budget assumed the employment of AHP1 base grade social workers.

The Commission does not endorse the use of call agents for a number of reasons. First, the proposal assumes the tasks of receiving calls and assessing notifications can be separated, when they are fundamentally intertwined. It stands to reason that experienced, qualified practitioners commence their assessment during the telephone call. They begin to identify areas of concern and ask questions to explore those areas to produce a more comprehensive assessment.

A pre-prepared script, no matter how detailed, is no substitute for practical experience and theoretical learning. Call agents would inevitably miss important cues and therefore fail to obtain crucial details. They would not have the same depth of knowledge as an experienced social worker to be able to divert from a script when necessary, to be flexible in how information is elicited and to ask the right questions. Social workers would then be left to make screening and response priority assessments based on information that is sub-optimal. In these circumstances there is a real danger that a child’s safety would be placed at risk through an inaccurate assessment being made on the basis of incomplete information.

The critical work of social workers at the point where children come to the attention of the state’s child protection system cannot, and must not, be reduced to a script followed by call agents.

At a practical level, the Executive Change review’s proposal insisted that call agents would overcome ‘inefficiencies’. However, it is hard to avoid the conclusion that it would result in inefficient double handling. There
is also significant risk of miscommunication of a child’s circumstances from notifier to call agent to social worker. Notifiers would surely prefer to speak to the person undertaking the assessment.

The use of call agents should not be presented as answering the underlying problem of resourcing the Call Centre. Even if call agents could answer the projected 60,000 calls a year, those notifications would still need to be assessed by social workers. The proposal identified a high risk that social workers might not be able to keep pace with the incoming notifications received by the call agents. The only countermeasures proposed were to increase reporting, accountability and benchmarks for workers, to be developed after the model is implemented.165

As discussed above, there are significant system, rather than workforce, impediments to processing notifications and there are real flaws associated with applying benchmarks to Call Centre work. In any event, it is unacceptable to identify a high risk that social workers could be overwhelmed and recommend that mitigating measures are developed only after the pilot commences.

The main justification for call agents is their ability to receive more calls and to record them more quickly, therefore reducing waiting times. This is a worthwhile objective. However, activating the call-back feature is a better alternative. It would avoid callers having to wait on the line without the drawback of separating the receiving and recording of the notification, from its assessment.

**MANDATED NOTIFIER TRAINING**

The Act does not expressly require notifiers to undergo mandatory notification training. Instead, section 8C requires government and non-government organisations that provide health, welfare, education, sporting or recreational, religious or spiritual, child care or residential services wholly or partly for children to develop child-safe policies and procedures. These may vary depending on the size, nature and resources of the organisation, but must comply with principles published by the chief executive of the Department. The principles include ensuring that volunteers and employees are able to identify and respond to children at risk of harm and are aware of their responsibilities to report under the Act.166

As a matter of policy, Families SA recommends that new mandated notifiers complete a seven-hour training program, with a three-hour refresher course every three years, but there is no obligation on section 8C organisations to follow this recommendation, nor is there any individual obligation on mandated notifiers to complete training.167

The statutory scheme for mandatory notification training should be streamlined. The current list of persons obligated to notify is wide and captures, for example, a variety of professionals who may work exclusively in aged care or very rarely come into contact with children.168 As discussed above, if those professionals come across information in their employment that indicates suspected child abuse, they should be required to report it. However, it is unduly onerous to require all mandated notifiers to complete training.

Some groups of mandated notifiers by virtue of their occupation or the nature of their work are more likely to come into contact with children. The Commission recommends the following categories of notifiers be obliged to complete training:

- registered teachers;
- general medical practitioners;
- police officers; and
- other mandated notifiers who are employees of, or volunteer in, a government or non-government organisation that provides health, welfare, education, sporting or recreational, child care or residential services wholly or partly for children, where the notifier either (a) is engaged in the actual delivery of those services to children or (b) holds a management position in the relevant organisation, the duties of which include direct responsibility for, or direct supervision of, the provision of those services to children.

Table 7.17 shows that the vast majority of notifications are made by mandated notifiers, a proportion that has risen in recent years.

**Table 7.17: Total notifications by mandated notifier status, 2011/12 to 2014/15**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total notifications</th>
<th>Notifications by mandated notifiers</th>
<th>Notifications by non-mandated notifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>40,507</td>
<td>31,254 (77%)</td>
<td>9,253</td>
</tr>
<tr>
<td>2012/13</td>
<td>43,539</td>
<td>35,290 (81%)</td>
<td>8,249</td>
</tr>
<tr>
<td>2013/14</td>
<td>48,837</td>
<td>41,825 (86%)</td>
<td>7,012</td>
</tr>
<tr>
<td>2014/15</td>
<td>57,810</td>
<td>50,243 (87%)</td>
<td>7,567</td>
</tr>
</tbody>
</table>

Source: Data provided by Families SA.
7 IDENTIFICATION AND NOTIFICATION

By targeting training to mandated notifiers involved in providing services to children there is significant potential to improve the quality of reports that are received generally by the Call Centre.

Families SA runs a three day train-the-trainer program and accredits training providers to provide mandated notification training. There are currently about 900 approved trainers. The Families SA Learning and Practice Development unit, responsible for overseeing the training, does not know what training the trainers are actually delivering. The unit is rewriting the train-the-trainer program.\textsuperscript{169}

The Commission heard evidence that Families SA ‘lost control’ of the training when it handed it to private providers.\textsuperscript{168} The quality of training currently varies markedly. There has been a proliferation of approved training organisations and key messages are being missed, including the types of matters that need to be reported. The Agency should take greater control of training so that messages in training more closely reflect a notifier’s obligations.\textsuperscript{170} It would be beneficial to have training organisations and key messages are being marked. There has been a proliferation of approved providers.\textsuperscript{170} The quality of training currently varies greatly. Teaching notifiers to use this guide should be incorporated in the mandatory notification training. There are currently about 900 approved trainers. The Families SA Learning and Practice Development unit, responsible for overseeing the training, does not know what training the trainers are actually delivering. The unit is rewriting the train-the-trainer program.\textsuperscript{169}

The Agency, as the peak body responsible for child protection, should take charge of the content and provision of this training. For example, the training should not be limited only to the process of making a notification, but extend to identifying the signs of possible abuse or neglect in children and how to respond to those signs. The Act should permit Families SA to prescribe the form of that training and to approve certain training providers to provide that training. Providers who cannot demonstrate they are communicating key messages should have their accreditation revoked.

As discussed above, Families SA has proposed developing a mandatory notification guide, similar to that used in New South Wales. Teaching notifiers to use this guide should be incorporated in the mandatory notification training.

FEEDBACK TO NOTIFIERS

The Commission received numerous submissions indicating that notifiers do not receive sufficient feedback from Families SA concerning their notifications, for example, whether the notification was screened in, what response priority rating it received and what practical response Families SA intends to take to address the concerns.\textsuperscript{171}

Providing appropriate feedback to notifiers is critical. If notifiers do not receive feedback, it undermines their ability to provide the family with ongoing support. They might, for example, assume that a family is receiving support when they are not. Indeed, lack of feedback to notifiers tends to fuel the perception that their responsibility ends with the notification. Out of frustration at a perceived lack of response, notifiers who do not receive feedback might be provoked to make multiple notifications with no new information.

All notifiers are entitled to be advised by the Call Centre whether their notification was screened out and on what basis and, if it was screened in, the response priority rating that was applied. It is particularly important that notifiers are advised if their notification was classified as a NOC, and why. This would help to educate notifiers about the extent of information that is required and the thresholds that the Agency applies to determine whether to respond to child protection concerns.

Given the workload of the Call Centre and the relative ubiquity of electronic communication, feedback of this sort should generally be provided electronically. Currently, the system does not provide automated electronic feedback of this kind. To ensure the already scarce capacity of practitioners would not be affected, a function to facilitate feedback to notifiers should be developed as a priority.

The Call Centre is reluctant to provide feedback as it does not know whether the Assessment and Support teams have the capacity to respond to screened-in notifications or will decide to close them without assessment.\textsuperscript{172} This reluctance is misplaced. As discussed in Chapter 9, the current Closed No Action (CNA) rate is unacceptable and must be addressed. In the meantime, if an Assessment and Support team decided to close a screened-in notification without assessment, providing feedback to notifiers would afford some accountability for that decision. The notifier is entitled to know both the response priority rating, if and when it is applied, and if the file were to be closed with no assessment. If the Agency cannot respond to the child, then it must at least advise the notifier and give them the opportunity to support the child and family in some other way, if possible.

Current advice to Call Centre practitioners emphasises that information is confidential and should only be shared with notifiers under the South Australian Government’s Information Sharing Guidelines for Promoting Wellbeing and Safety (ISGs) where ‘a child or young person is in immediate danger’.\textsuperscript{173} That advice is too narrow. The ISGs were amended in 2013 and now extend to non-immediate threats to child wellbeing, including situations of cumulative harm and chronic neglect.\textsuperscript{174} There would be very few circumstances brought to the attention of the Call Centre that would not satisfy this definition. Chapter 21 discusses the need for an expanded duty for agencies to share information more proactively where this promotes child safety and wellbeing. The Call Centre’s procedures need to be revised in light of those recommendations.
The Commission recommends that the South Australian Government:

31 Maintain the current mandatory reporting threshold set out on section 11 of the Children’s Protection Act 1993.

32 Review the screening and response priority tools to ensure they give due weight to cumulative harm, chronic neglect, social isolation, underlying causes of dysfunction, the need to conduct timely forensic medical assessments, and the expertise and experience of professional notifiers.

33 Review screened-out notifications periodically to ensure the threshold is being correctly applied.

34 Invest in the professional development of the Agency’s Call Centre practitioners, including, but not limited to:
   a the implementation of case reading;
   b regular clinical supervision;
   c the introduction of a tailored induction program; and
   d ongoing training in the specific skills required of Call Centre practitioners.

35 Implement the automated call-back feature at the Call Centre for a trial period, followed by an assessment to determine whether its ongoing use is justified.

36 Staff the Call Centre at a level that would permit the achievement of the following service benchmarks:
   a a maximum waiting time of 30 minutes for a telephone call to be answered;
   b a maximum of 24 hours to assess an eCARL notification; and
   c a maximum delay of two hours for a call back.

37 Ensure that the Call Centre is never left unattended. Crisis Care staffing levels should be immediately increased to no fewer than three staff at each shift.

38 Abandon the proposal to engage unqualified call agents to receive telephone notifications. Telephone calls from notifiers must only be taken by degree-level, tertiary qualified and experienced practitioners.

39 Update, as a matter of urgency, public information concerning the services offered by the Crisis Care service.

40 Provide automated electronic feedback to all notifiers, confirming receipt of their notification (in the case of eCARL) and, post-assessment, what screening and response priority assessments were made in relation to their notifications.

41 Record notifications directly into an electronic log sheet that pre-populates the C3MS intake record.

42 Review and improve the efficiency of recording practices of Notifier Only Concerns (NOCs).

43 Ensure the Agency regains control of, and strictly oversees, mandatory notification training, including creating and updating an appropriate training package and a mandatory notifiers’ guide, and regularly auditing training to ensure fidelity.

44 Make mandatory notification training compulsory for:
   a registered teachers;
   b general medical practitioners;
   c police officers; and
   d other mandated notifiers who are employees of, or volunteer in, a government or non-government organisation that provides health, welfare, education, sporting or recreational, childcare or residential services wholly or partly for children, where the notifier either (a) is engaged in the actual delivery of those services to children or (b) holds a management position in the relevant organisation, the duties of which include direct responsibility for, or direct supervision of, the provision of those services to children.

RECOMMENDATIONS
7 IDENTIFICATION AND NOTIFICATION

RECOMMENDATIONS

45. Restrict access to eCARL to notifiers who have completed mandated notifier training.

46. Include an interactive mandatory notifier guide at the start of eCARL.

47. Amend Part 4, Division 1, of the Children’s Protection Act 1993 to include a new provision permitting, but not requiring, a notifier to report concerns about an unborn child, regardless of the stage of pregnancy.

48. Abandon the policy restricting the recording of Report on Unborn (ROU) children to 34 weeks’ gestation or later.
NOTES


3 B Mathews, Mandatory reporting laws, p. 127.


5 Children’s Protection Act 1993 (SA), s. 11.

6 Children’s Protection Act Amendment Act 1969 (Act no. 49) (SA); B Mathews, Mandatory reporting laws, pp. 83–84.

7 Children’s Protection Act 1993 (SA), ss. 6, 10.


17 Children’s Protection Act 1993 (SA), ss. 6(1), 11.

18 For the purposes of this report, screened-in notifications are limited to Tier 1, Tier 2 or Tier 3 intakes, excluding Extra-familial (EXF) matters which, although technically ‘screened-in’ for some statistical purposes, are referred to South Australia Police.


21 Oral evidence: K Taheny; S Nicholls.


28 These statistics exclude notifications that the relevant statutory agencies screen out as not meeting the threshold for a child protection notification. Australian Institute of Health and Welfare, Child Protection Australia 2014–15, series no. 63, cat. no. CWS 57, AIHW, Australian Government, Canberra, 2016, pp. 1, 80.

29 Oral evidence: Name withheld (W74).


31 Oral evidence: S Cookes.

32 See, for example, L Novak, ‘Families SA hotline clogged, with half of calls unnecessary’, The Advertiser, 21 October 2015, p. 1.

33 Oral evidence: M Hood; name withheld (W74).

34 Oral evidence: D O’Hare.

7 IDENTIFICATION AND NOTIFICATION

NOTES

36 Oral evidence: Name withheld (W37); C Pearce; R Whitten.
37 Oral evidence: D Ketteridge.
38 Submission: Uniting Communities.
40 Oral evidence: D O’Hare.
41 Oral evidence: C Keogh; S Macdonald; S Nicholson; name withheld (W111).
42 Children, Youth and Families Act 2005 (Vic.), s. 29; Children and Young Persons (Care and Protection) Act 2008 (NSW), s. 25.
46 ibid.
47 ibid., p. 2.
48 See also Families SA, Care and protection assessment policy, internal unpublished document, 2007, p. 1
49 Oral evidence: C Keogh.
52 Oral evidence: C Keogh.
54 ibid., p. 24.
56 Oral evidence: C Keogh.
57 Oral evidence: S Smith.
63 Oral evidence: C Keogh.
64 RA Layton (Chair), Our best investment, pp. 9.34.
65 ibid., recommendation 46.
66 Families SA, ‘Redesign Call Centre business case’, p. 32.
67 Oral evidence: S Smith.
68 Oral evidence: C Keogh.
69 Oral evidence: S Skilbeck.
72 This is a measure of attempted telephone calls to the Call Centre that are abandoned by the caller.
74 Oral evidence: R Skillbeck.
76 Oral evidence: S Cookes; name withheld (W72); name withheld (W74); S Smith.
77 Average talk time measures the average time a Call Centre practitioner spends speaking on the telephone to a notifier.
78 The benchmark relates to the number of children, not notifiers. For example, a single telephone call concerning a family of three children would count as three notifications for the purposes of this benchmark.
79 Families SA, ‘Redesign Call Centre business case’, p. 18.
80 Oral evidence: S Smith.
82 Oral evidence: S Smith.
83 The Diversion Assessment Response Team was dedicated to receiving telephone calls from notifiers from the education sector. It had a ‘diversionary’ focus, supporting notifiers to respond directly to concerns without the need for Families SA’s direct intervention. The team has now changed focus and is known as Linking Families.
84 The Yaitya Tirramangkotti team was responsible for receiving notifications about Aboriginal and Torres Strait Islander children. It has changed focus and is now based at the Central Assessment and Support Hub.
86 Oral evidence: R Skillbeck.
87 Oral evidence: C Keogh.
88 Oral evidence: Name withheld (W74).
89 Families SA, ‘Redesign Call Centre business case’, p. 19.
90 Oral evidence: C Keogh.
92 Families SA, Executive paper regarding the implementation of Structured Decision Making case reading at Crisis Response Unit and development of procedures and practice guide, internal unpublished document, 2013.
94 Families SA, ‘Executive paper regarding the implementation of Structured Decision Making’, 2013.
96 E Scheepers, letter to the Child Protection Systems Royal Commission, 23 November 2015.

Some oral evidence, witness statements and submissions were received on a confidential basis.
The source is known to the Commission, and is identified by a number in the endnotes.
IDENTIFICATION AND NOTIFICATION

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NOTES

168 *Children’s Protection Act 1993* (SA), s. 11(2).
169 Oral evidence: Name withheld (W29).
170 Oral evidence: C Keogh.
172 Oral evidence: C Keogh.
173 For example, Oral evidence: D Ketteridge; K Tomlian.
174 Oral evidence: C Keogh.

Some oral evidence, witness statements and submissions were received on a confidential basis. The source is known to the Commission, and is identified by a number in the endnotes.
# EARLY INTERVENTION

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OVERVIEW

Where a child’s family has the capacity and skill to provide safe and nurturing care, then that is overwhelmingly the best place for that care to be provided. The existence of the child protection system is, however, a testament to the fact that some parents struggle to provide appropriate care. For some families, the provision of timely, adequate support will allow them to make the changes needed to provide safe care before problems become entrenched and escalate, ultimately requiring statutory intervention by Families SA (the Agency)—by which time the children have already suffered harm.

To prevent child abuse and neglect, the public health model of child protection promoted in the National Framework for Protecting Australia’s Children 2009–2020 (the national framework) emphasises investment in programs (both universal and targeted) delivered at the primary and secondary services levels. Consistent with this national focus, which is supported by a growing evidence base, an improved child protection system in South Australia should aim not merely to respond better to child maltreatment, but to prevent it in the first place.

In recent years, South Australia has under-invested in services for at-risk families. The state should make a greater investment in early intervention services that target families with known risk factors for child abuse and neglect, and that deliver evidence-based interventions. There are also opportunities to build on existing, adult-focused government services to include a focus on children. If an investment in new services is to be effective, formal pathways should be established to link families into services, and to link the data gathered by these services to the statutory system. For a number of reasons, the statutory system is an inappropriate route for early intervention referrals to be received and actioned.

South Australia has an existing network of mandatory notifiers who work in health, education, law enforcement and community organisations and who have regular contact with children. There is an opportunity to ask these people to consider whether it might be more appropriate, and more productive, to refer families to relevant services, effectively bypassing a report to the Agency.

Such an alternative for mandatory notifiers would require an accessible local referral point, which would also perform as a coordinated local intake point for service users. By positioning this intake point at the local level, there would be opportunities for data to be gathered and analysed about service needs at this level.

This chapter principally relates to the Commission’s Terms of Reference 5(a) and 5(b), in the context of Terms of Reference 1 to 4.

THE ARGUMENTS FOR EARLY INTERVENTION

Early intervention is defined as:

Interventions directed to individuals, families or communities displaying the early signs, symptoms or predispositions that may lead to child abuse or neglect.1

It is not limited to interventions in the early years of a child’s life, but includes work delivered early in the development of a problem.2 The inter-generational nature of child abuse and neglect means that any intervention along the causal pathway could be considered early intervention because it relates to the next generation. For example, risk factors can usually be identified well before a woman becomes pregnant. Children who have suffered abuse or neglect are at heightened risk of facing challenges in their own parenting. To avoid this, therapeutic work with late adolescents and young adults who have been abused or neglected can help them recover from trauma and can also better equip them for parenthood.3

There are at least three arguments in favour of early intervention. First, early intervention offers an opportunity to interrupt painful, adverse experiences for children; experiences that could profoundly damage their later development and opportunities.4 Article 19 of the United Nations Convention on the Rights of the Child requires parties to take all appropriate legislative, administrative, social and educational measures to protect children from all forms of maltreatment. This includes measures that not only identify and respond to maltreatment in a reactive sense, but also prevent it from occurring in the first place.5

The second argument is to act ‘now or never’.6 Damage caused by abuse and neglect is difficult, sometimes impossible, to reverse. For example, the child’s brain develops rapidly in the first 18 months of life. Maltreatment interrupts this development, undermining the child’s ability to develop empathy, regulate emotions and develop social skills. It places the child at risk of a range of future difficulties, including poor mental health and antisocial behaviour. It follows that intervening early may be the only opportunity to address these problems successfully.7

Third, because it is costly and difficult to try to solve these problems in adulthood, early interventions are often a cost-effective and prudent use of public resources.8
The Commission’s consultation with children and young people (see Appendix B) revealed that children at the centre of the child protection system want parents who experience challenges to be supported to change. Where possible, they want to be able to remain with their parents, as long as they can be safely cared for. A number of children understood that some adults were not capable of making the changes that were necessary, but they wanted their parents to have that chance. They wanted people who knew parents were experiencing challenges to get involved, and early.9

INCREASING SERVICES

COST EFFECTIVENESS OF EARLY INTERVENTION

Child abuse has significant economic costs, including in health care, child protection services, policing, correctional services, reduced productivity of victims and premature death. In 2007, the cost of abuse and neglect in Australia was estimated to be about $4 billion a year, with burden of disease10 adding $6.7 billion a year.11 The combined cost of $10.7 billion was almost three times the cost of obesity in 2005 ($3.8 billion).12

The economic costs of child abuse and neglect show that prevention and early intervention are fiscally prudent investments

The lifetime cost of children experiencing abuse or neglect for the first time in 2007 was estimated at $6 billion, with burden of disease adding $7.7 billion.13 Child abuse is associated with a number of negative outcomes, which can be estimated in economic terms. Where interventions are effective, ‘downstream budget costs’ are avoided.14

Using the figures cited above, against the number of new substantiations according to productivity commission data for 2007, a potential saving of $245,000 per child has been estimated for each case of maltreatment prevented. This is an average saving. Costs and potential savings are significantly higher for some children, such as those who go on to develop severely disturbed behaviours.15

In addition to the powerful moral arguments for early intervention, these figures show there is a strong economic incentive to prevent and reduce child maltreatment. They position prevention and early intervention as fiscally prudent investments.

A review of early intervention options in the United Kingdom found that many were ‘astoundingly good value for money’16, offering a range of pay-offs for the public sector and for society more broadly. Benefits were sometimes spread over many years, but generally costs were fully recovered in a relatively short time. It noted evidence of potential savings in the six years following the intervention. For every £1.00 of expenditure, the savings were17:

- £7.89 for parenting interventions to prevent persistent conduct disorders in their children;
- £83.73 for school-based social and emotional learning programs; and
- £11.75 for GP screening for alcohol misuse.

ADEQUATE FUNDING OF PREVENTION AND EARLY INTERVENTION

The Children’s Protection Act 1993 (SA) imposes a number of functions on the relevant Minister that are related to furthering the objects of the Act. These functions are not limited to actions at the tertiary end of child protection. They include:

- ‘to promote and assist in the development of coordinated strategies for dealing with the problem of child abuse and neglect’18;
- ‘to provide or assist in the provision of preventative and support services directed towards strengthening and supporting families, reducing the incidence of child abuse and neglect, and maximising the wellbeing of children generally’19; and
- ‘to assist the Aboriginal community to establish its own programs for preventing or reducing the incidence of abuse or neglect of children within the Aboriginal community’.20

The Layton Review, published in 2003, recommended a greater focus on evidence-based early intervention and prevention services.21 It included recommendations for changes to the early intervention and prevention system to improve accessibility, planning and service coordination. It also recommended a greater focus on strategic planning.

Despite the fact that 13 years have passed since the Layton Review, a consistent theme of witnesses and submissions to the Commission was that South Australia does not sufficiently fund early intervention services.22 National comparisons bear out this criticism. The Productivity Commission keeps statistics on spending by Australian governments on a range of areas in child protection services. These statistics need to be read with some caution because individual governments record spending in different ways. However, the broad picture is clear. Figure 8.1 and Figure 8.2 compare South Australia’s expenditure per child on family support services and intensive family support services.
Figure 8.2: South Australian intensive family support services’ expenditure per child compared with the Australian average, 2006/07 to 2014/15

Note: Intensive family support services are specialist services that aim to prevent the imminent separation of children from their primary caregivers as a result of child protection concerns, and reunify families where separation has already occurred. They are intensive in nature, averaging at least four hours of service per week for a specified short period that is usually less than six months and generally respond to referrals from a child protection service.


Figure 8.1: South Australian family support services’ expenditure per child compared with the Australian average, 2013/14 to 2014/15

Note: Family support services include activities typically associated with the provision of lower level, non-intensive services to families in need. They include identification and assessment of family needs, provision of support and diversionary services, some counselling, and active linking and referrals to support networks.

Other Australian jurisdictions have reported spending on family support services since 2011/12, but South Australia has produced data only for 2013/14 and 2014/15. However, the available statistics show that the state’s spending per child in 2014/15 was the second lowest in Australia (ahead of Queensland), at 43 per cent of the national average, a rise from 31 per cent in 2013/14.

South Australia’s spending per child on intensive family support services has lagged behind the national average for many years, although this gap has narrowed during the past three financial years. The state’s spending per child in 2014/15 remained the third lowest in Australia (ahead of Western Australia and the Australian Capital Territory) and only 80 per cent of the national average.

Figure 8.3 shows South Australia’s real recurrent expenditure in four key areas of child protection.

The rapid rise in out-of-home care has dominated spending, with spending on child protection services, family support and intensive family support services remaining steady. The rise in spending on out-of-home care reflects growth in emergency and residential care at the expense of relative care and foster care. Figure 8.4 compares spending in 2014/15 in the four key areas of child protection.

In 2014/15, South Australia spent 71 per cent of its child protection budget on out-of-home care alone and 20 per cent on child protection services, leaving only 6 per cent and 3 per cent respectively for intensive family support services and family support services. Statistics such as these cause child protection experts to refer to the Australian system as an ‘inverted pyramid’, which invests disproportionately at late stages in the system at the expense of prevention and early intervention.23 It could be compared to a health system without a general practitioner service, requiring hospital emergency departments to respond to every cold or minor infection.24

Some submissions to the Commission argued that the system should redirect resources from the tertiary end into early intervention.23 In a similar vein, a recent United Kingdom study observed:

A small shift in the balance of expenditure from treatment to prevention/promotion should generate efficiency gains.26

This is an attractive proposition and should represent a medium-term ambition. Over time, investment in early intervention should prevent child maltreatment and save significant public revenue in other areas, including tertiary child protection.

However, it is plainly false that the child protection system currently conducts too much tertiary intervention or that the threshold for Families SA to investigate and exercise its statutory powers to keep children safe is too low. To the contrary, the Commission found many examples of children left in situations of significant danger to their health, safety and wellbeing for prolonged periods of time. As discussed in Chapter 9, far too many screened-in notifications are coded as Closed No Action or given a cursory assessment that cannot hope to explore the needs of children and their families, far less ensure that those needs are met.

In the short term, the contest between primary, secondary and tertiary interventions is a false one. As discussed above, there is a strong economic as well as moral case for investing in early intervention; however, under-investing in tertiary interventions to protect children who are in demonstrable danger is an affront to those children’s human rights. While there should be an expansion of early intervention and preventative services, this cannot be at the expense of tertiary intervention, which should, for a time at least, expand to protect the many vulnerable children whose urgent needs are unmet.

SELECTING THE RIGHT INTERVENTIONS

It is critical that additional investment in early intervention should represent value for money and be aligned to the necessary outcomes. Poor quality or inappropriate intervention programs waste public money and can further damage families.

The offering of services that are funded at a local level should be matched to the social issues that confront families in that area. Efforts should be directed towards using data to build a picture of local needs, so that services can be tailored to the needs of the community. For example, in communities where high numbers of children are identified as at-risk because of domestic violence, a substantial investment in a generic family support or parenting skills program is unlikely to yield great benefits. However, communities with high numbers of very young or new parents might benefit from programs on parenting or addressing social isolation. Research should also be aimed at establishing the effectiveness of such programs in meeting the community’s needs.
Figure 8.3: South Australia’s real recurrent expenditure on child protection services, out-of-home care services, intensive family support services and family support services, 2011/12 to 2014/15

Note: Child protection services refer to the functions of government that receive and assess allegations of child abuse or neglect and/or harm to children; provide and refer clients to family support and other relevant services and intervene to protect children. Out-of-home care refers to overnight care, including placement with relatives (other than parents) where the government makes a financial payment, including subject to an order or under a voluntary arrangement, but excluding placements solely funded by disability services, psychiatric services, youth justice facilities and overnight child care services.


The Family by Family program

Family by Family is an early intervention program offered in four areas of Adelaide, as well as Mt Druitt in Western Sydney. It is run by the Australian Centre for Social Innovation. The program recruits two cohorts: ‘seeking’ families, who are experiencing problems they want to change, and ‘sharing’ families, who have dealt with similar problems and are willing to share what they have learned. The program tackles a range of problems, including poor financial management, isolation, inappropriate age expectations, poor discipline, neglect, poor mental health and parental substance abuse.

Professional coaches match each seeking family with a sharing family in a 10-week ‘link-up’. Sharing families spend up to three hours a week with the seeking family, helping them to set goals to overcome their difficulties and connect with new people, places, groups and services in their community. The coaches help sharing families with training, support and ideas for activities and community resources. Seeking families who need more time to work on their goals can do multiple link-ups. Sharing families receive a small grant to cover out-of-pocket expenses.1

The matching process appears successful, with few families wanting to be removed from the program once they have been linked up. The program is relatively low cost and non-stigmatising:

There’s something nice about being with somebody who can give you a little bit of a hard word sometimes, but is coming from a place of truly understanding what you feel and what you experience. So that seems to be why people come.2

The program has kept data to track changes for seeking and sharing families over time. An early evaluation in 2012 found 80 per cent of seeking families said things were ‘better’ or ‘heaps better’ at the second coaching session and about 90 per cent at the subsequent sessions. Interviews with families, Families SA workers and Family by Family staff identified positive outcomes in relation to confidence and self-esteem and a variety of positive outcomes for children, including areas relevant to child development.3 A more extensive evaluation is expected later in 2016.

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1 The Australian Centre for Social Innovation (TACSI), Family by Family explained for professionals, TACSI, Adelaide, 2012.
2 Oral evidence: Dana Shen.
Not all intervention programs are created equal. A 2012 review of 33 infant home visiting programs across a number of western countries found their cost effectiveness varied significantly. The estimated cost per case of maltreatment prevented varied from $22,000 to several million dollars. Seven programs were found to be cost saving, with regard to lifetime costs. In light of this variation, programs should be carefully selected and targeted to ensure they produce the intended social benefits.27

Yet in practice many services are funded: without a clear practice or program model and without being underpinned by an evidence base. These services run the risk of being ineffective and thus failing to aid in the prevention of child abuse and neglect. At worst, they may do further harm to highly vulnerable children and families.28

In the place of a sound evidence base to establish their effectiveness, many programs rely on the confidence of front-line workers. This confidence may be misplaced. The shift to evidence-based practice in fields such as medicine recognises that ‘experts’ may be poor judges of the efficacy of their interventions: the wisdom of front-line workers should be supplemented by testable, independent research data.29

One complication of this approach is that much of the outcomes-based data for existing interventions comes from other countries, particularly the United States of America. While this is a useful starting point, there are significant differences between Australia and other countries. Findings from one community cannot necessarily be applied without further analysis in another:

The costs and benefits for any given program are specific to the environment in which they are implemented. The demographics of the target population, labour market conditions and local infrastructure are just three examples of important contextual factors that can significantly change the costs and benefits of programs.30

Successful pilots in the United States have not always been replicated successfully elsewhere.31 Even when programs have a strong evidence base, attention should be paid to program design and implementation to ensure that the positive outcomes are replicated in the local environment.32

These challenges do not mean that interventions should not be pursued: many service models are effective in supporting vulnerable families and improving outcomes for their children. Instead, it underscores the need to ensure that funding of services is determined by the best available evidence and is accompanied by ongoing, robust independent research to build knowledge about the interventions most effective in South Australia.33

GOVERNMENT MEASURES TO RESPOND TO VULNERABLE FAMILIES

In recent years, a number of South Australian Government agencies that have frequent contact with vulnerable families have adopted measures to better equip their staff to support the families. Government services whose primary mandate is service delivery to adult clients can deliver preventative services by shifting their focus to also consider the needs of children in the family setting.

Such services might also be effective in providing less stigmatising pathways for families into appropriate support. That is, where intensive assistance is offered as a follow-on (without the need for a new referral) from a universal service such as new-born home visiting, clients are much less likely to see that service as identifying them as a ‘poor parent’ or their children as ‘at risk’.

For these reasons, it is critical that agencies in frequent contact with at-risk families are part of coordinated service provision to be developed at the local level. The initiatives described below form a solid basis for growth in the government services contribution to early intervention.
HOUSING SA

Housing SA administers South Australia’s stock of public housing and supports people to access the private housing market and housing offered by the not-for-profit sector. Its new service model has shifted the agency’s focus from managing assets to engaging the people who receive its services. In particular, it equips staff to consider the needs of children. By responding earlier to problems, it is designed to reduce the risk of harm to children and to prevent families from entering the child protection system.34

The model aims to recruit front-line workers with skills in engaging clients in order to identify potential issues. Each such worker is responsible for a geographical area: the households, as well as local services such as schools and community centres. They use a risk identification tool (RIT) to identify risk and vulnerability and respond accordingly. While many Housing SA staff are mandated notifiers, they are encouraged to view their role as not only notification, but also engaging and supporting clients in relation to the issues identified.35

The service model introduces two specialist support-focused roles:

- Tenancy practitioners offer tailored support to households identified by the RIT to be at moderate risk. They make referrals to, and collaborate with, other government and not-for-profit services. They also provide direct assistance; for example, by helping a family to start the day, prepare breakfast and lunch, and get the children to school. If a mother is isolated and her children are at school, the practitioner might discuss opportunities to enrol in training or volunteer in the community.36

- Regional Response Teams deliver multidisciplinary, specialist case management for households identified by the RIT to be at high risk. The teams include social workers, senior Aboriginal consultants, community development workers and community response coordinators. They respond to all concerns relating to child protection, domestic violence and imminent homelessness.37

Housing SA aims to visit all tenancies at least once a year. Staff are encouraged to focus on the people in the house, rather than simply the asset. In particular, staff should sight children under five years of age who are known to reside at the property, and to ask questions if a child is not present and to explore potential issues. For example, if there are no toys or bed in the bedroom, workers should ask where the child is sleeping. All service delivery staff and their managers are trained in issues such as child protection, domestic violence and child development to instil an understanding of children as clients in their own right, whose needs should be prioritised.38

DRUG AND ALCOHOL SERVICES SOUTH AUSTRALIA

Drug and Alcohol Services South Australia (DASSA) workers have frequent contact with adult clients who care for dependent children.39 In recognition of this, DASSA has moved to adopt child and family sensitive practice (CFSP), which is defined as:

raising awareness of the impact of substance abuse upon families, addressing the needs of families and seeing the family—rather than an individual adult or child—as the unit of intervention. It necessitates identifying and addressing the needs of adult clients as parents, as well as the needs of their children, as part of treatment and intervention processes, in order to ensure that as parents they are supported and child wellbeing and safety [are] maintained.40

The approach has broad support across Australia.41

In 2012, DASSA reviewed its implementation of CFSP. The evaluation found that staff supported it and were committed to using it with clients, but faced key barriers, such as a lack of organisational support (including appropriate policy and guidelines), insufficient training, heavy workloads, and competing priorities concerning the needs of the client and his or her family.42

The review recommended improved policy and procedure, increased educational and training opportunities, and the introduction of professional and clinical supervision and clinical guidelines. These measures required modest additional resources and were implemented either as recommended or by an equivalent measure. For example, the Australian Centre for Child Protection helped develop staff training on issues such as the effect of parental substance use on children.43

The review recommended that a resource person be identified for each DASSA site as a CFSP ‘champion’. The person would be the repository of relevant information, help upskill new staff and supervise where appropriate. DASSA invited expressions of interest from staff at each site to serve in this role.44

A final recommendation stated that DASSA should consider establishing a specialist position to oversee its approach to child and family sensitive policy and practice. The position was to be at least the level of senior clinician in nursing, social work or psychology, with substantial prior experience in child and family sensitive practice. It was estimated to cost about $100,000 a year. This has not been implemented because of limited resources.45

A practice leader of this kind would likely bring coordination and focus to DASSA’s work in this area. However, the Commission does not have sufficient evidence to recommend that the role be established ahead of the agency’s other priorities. Instead,
DASSA should consider an updated evaluation of the measures implemented so far, to assess whether this recommendation has continuing potential.

WOMEN’S AND CHILDREN’S HEALTH NETWORK
The Women’s and Children’s Health Network (WCHN) has used research commissioned from the University of Adelaide to form the basis of its service reform plan. The research sets out five basic development domains (physical, language, attachment, social/emotional and cognitive) that children should achieve in five stages (pregnancy, postnatal, infancy, toddlerhood and early childhood) before starting school.46

The WCHN offers a nurse home visit soon after birth for every child born in South Australia. The service aims to identify family, child development and health issues early, and to promote optimal development through early access to child health services, parenting information and support pathways for families. In accordance with the principle of proportionate universalism, families identified with particular needs are offered extended home visits over two years. Home visiting offers practical support to develop parenting skills, but is not necessarily equipped to support families with more complex needs who might find the service more of ‘an irritation’47, than a help.48

For those families, the WCHN’s Wellbeing teams and Strong Start teams offer intensive, ongoing interventions, staffed by multidisciplinary workers. The Wellbeing teams work with families at moderate risk and Strong Start teams with those at higher risk. In Adelaide, Wellbeing teams operate in the northern and western suburbs and Strong Start teams in the northern and southern suburbs.49 These services promise a flexible response that is proportionate to the needs of vulnerable families. However, as discussed below, the teams’ operations are limited by restrictive referral criteria.

There is significant potential for these health-oriented services to be a launching point for providing targeted services to address identified risk factors, especially in families with very young children.

AN INTEGRATED SYSTEM
Effective prevention and early intervention require an integrated system of primary, secondary and tertiary interventions (whether delivered by government, not-for-profit or community organisations) to identify and respond to the needs of vulnerable and at-risk families and their children. A public health approach, as advocated in the National Framework, involves more than providing generic services that fit the intensity level of universal, secondary and tertiary responses. It requires identifying and addressing the risk factors that compromise the safety of children in families, and delivering services that respond to those needs. Funding the right services, however, is not the end of the story. The right services should be delivered as part of a cohesive system that families can easily access and negotiate.

The coordination of services for vulnerable families has a range of potential benefits, including50:

• the ability to address complex, interrelated issues simultaneously;
• reduced financial costs, through identifying needs and targeting support earlier and reducing multiple visits to separate support services and duplication of services;
• improved access to services;
• improved information sharing and cooperation between service providers; and
• improved service quality, outcomes and satisfaction with service delivery among service users and providers.

Yet collaboration is a challenge:

There are good reasons why people don’t want to work together. So goodwill isn’t enough; you need a process requiring people to work together.51

In evidence and submissions, the Commission heard often that prevention and early intervention services in South Australia are fragmented and poorly coordinated. They are not commissioned in accordance with an overriding plan that emphasises the needs of children. Interventions by one agency do not complement those of others, and inconsistent, inflexible eligibility criteria leave large service gaps. Further, there is no easy way for practitioners and the public to become aware of the services available in their local area.52

As part of its evidence-gathering process, the Commission attempted to identify and map the major services being delivered by not-for-profit agencies that had the potential to deliver preventative or early intervention services. The task proved difficult and time consuming, and highlighted the challenges for vulnerable families in trying to negotiate the service system.
SERVICE GAPS

Referral criteria can usefully direct clients towards services that address their needs. However, inflexible criteria that do not consider system implications can leave vulnerable people without a service. For example, the Strong Start team offers intensive support to families with high level needs. They only work with first-time mothers referred before their child’s birth, who reside in certain northern or southern suburbs of Adelaide. An early evaluation of the program noted that there is little evidence to support limiting the service to families referred before birth. While recruiting prenatally may improve engagement with services, it excludes mothers whose issues present after birth, or who have not previously engaged with health care during pregnancy, or who birth early. Further, the service offers no support to families who reside outside its catchment: ‘If you live in Modbury, you don’t get this service’.53

‘If you live in Modbury, you don’t get this service’

The Wellbeing teams respond to families experiencing medium-level needs. Their criteria are more flexible than Strong Start’s and include accepting referrals before and after birth and for subsequent children; however, they are restricted to some northern and western suburbs.54 There is no equivalent service for clients in other suburbs or in regional and remote areas. Strong Start and Wellbeing teams are important service innovations, but their referral criteria exclude many families who need the service.

SERVICE SILOS

Families involved in the child protection system often experience multiple problems, for example, substance abuse, mental illness and/or domestic violence. This is known as comorbidity. Comorbidity of substance abuse and mental illness is particularly prevalent, with estimates that between 25 per cent and 80 per cent of mental health service users have substance abuse issues. Unless recognised and dealt with, this particular comorbidity ‘substantially impacts people’s mental and physical health and social wellbeing and significantly shortens their lives’.55

Yet support services tend to operate as silos, focusing on problems in isolation. For example, a mental health service may treat patients for depression and refer them on to another agency for their drug problem, often without sharing background information, including that the patient is a parent.

A recent review of mental health and alcohol and other drugs services in northern Adelaide found that services were delivered in isolation. Mental health service providers were neither trained nor equipped to respond to drug and alcohol problems, and vice versa. The treatment that people receive and the nature of the service provided depend on which service people first attend.56

The review made recommendations in support of an integrated system, including that57:

• mental health and alcohol and other drug comorbidity should be prioritised in state and federal policies, funding decisions and directions;
• all mental health and alcohol and other drug leaders, clinicians and workers should be knowledgeable and competent in delivering evidence-based comorbidity services as their ‘core practice’;
• mental health and alcohol and other drug services should avoid ‘silied’ service delivery and instead deliver evidence-based comorbidity services in which consumers are assessed and treated appropriately, no matter which service they seek help from
• government should establish a non-competitive funding and procurement model to enable the not-for-profit sector to deliver a sustainable, skilled workforce that can deliver evidence-based comorbidity services that can engage, maintain and assure consumer confidence and service improvements. Funding cycles should be run for a minimum of four to five years.

These are excellent recommendations and their intent is reflected in the Commission’s own recommendations. Parents with multiple, complex problems should not be given the service run-around:

When working with a parent who is dealing with multiple and complex problems, practitioners are likely to have to try to support them on different fronts. Referring the family to a different service or professional for each problem or trying to tackle all problems simultaneously will be overwhelming for the family. An effective intervention is planned and purposeful, based on a comprehensive assessment and staged to meet the family’s needs and capacities over time.58

Flexible service models should be funded to respond to common co-morbid problems, such as substance abuse and poor mental health. In other cases, one agency should be identified as case manager to ensure a coordinated, staged response.

FUNDING ARRANGEMENTS

Family support services in South Australia are provided by a mixture of public sector, not-for-profit agencies and community organisations. Individual agencies have their own organisational culture, skills and working conditions –differences that present additional challenges to collaboration.
These challenges are exacerbated by short-term funding arrangements that undermine employment security and make it harder for agencies to retain staff and build a strong culture that supports collaborative practice. Competitive tender processes pit not-for-profit agencies against each other in a way that can undermine future collaboration. Frequent, short-term tender cycles of three years or less leave little time between tenders to restore cooperative relationships:

\[ \text{Everyone just gets to a point where, yes, we are all}\]
\[\text{going to work together on this particular area and then}\]
\[\text{suddenly a competitive tender comes in and you are}\]
\[\text{pitted against each other.}\]^{19}

Accordingly, state government agencies should generally avoid short-term funding arrangements, preferring where possible to fund services for at least five years to improve employment security and allow more meaningful service evaluations. Agencies should explore alternatives to competitive tendering for family support services, such as preferred provider panels or a lead agency model, such as the Australian Government’s Communities for Children program.

**DIVERTING FAMILIES**

**THE CURRENT ENTRY POINT**

As discussed in Chapter 7, the Families SA Call Centre (commonly referred to as the Child Abuse Report line) is the central entry point to the statutory child protection system. People who suspect a child is at risk of being, or has been, abused or neglected must report this to the Call Centre; indeed, many professionals are legally obliged to do so.
Many vulnerable families are reported but do not get any response or service from the Agency, although they would benefit from a service referral. Concerned adults who report these matters generally become increasingly frustrated by the lack of action on their notifications, yet they have few other options if they want to access services to support families.

In recent years, total notifications have risen rapidly, yet screened-in notifications have remained relatively steady. In 2014/15, the Call Centre screened in only 33 per cent of all notifications received. However, many notifications coded for screening out as Notifier Only Concern (NOC), Adolescent at Risk (AAR) and Report on Unborn (ROU) could be dealt with through an early intervention response. Currently NOCs do not receive a response and AARs and ROUs receive a response only if resources are available.

Nor is the response to screened-in notifications much better. As discussed in Chapters 7 and 9, until recently Families SA’s response to Tier 3 intakes was to write a letter to the parents, inviting them to attend a meeting to discuss concerns, usually at the Families SA office. The meeting was voluntary and the letter stated that the concerns would not be investigated. Families SA did not generally visit the home or sight the child. The process has been criticised by successive reviews. Further, most Tier 2 and Tier 3 intakes are Closed No Action (CNA) due to a lack of resources.

The poor response to Tier 2 and Tier 3 intakes, and NOC, AAR and ROU notifications represents a lost opportunity to respond early to (relatively) less serious, less urgent concerns. Only when concerns escalate to a Tier 1 classification is a response guaranteed. In the meantime, parental problems become entrenched and children sustain significant, lasting trauma.

### FamilyZone, Communities for Children

FamilyZone is a children and family service hub located at the Ingle Farm Primary School and funded as part of the Communities for Children program (CfC). Under the CfC model, a not-for-profit agency is funded as the facilitating partner to consult with local stakeholders and prepare a whole-of-community plan for early childhood development for the area. The facilitating partner funds not-for-profit community partner agencies to provide services in accordance with the plan, including parenting support, case management, home visiting services and other supports to prevent child abuse and neglect. Some programs have a focus on supporting men to parent well. The model aims to improve service collaboration to benefit local children and families, whether or not they use CfC services.

A nationwide evaluation found that CfC had a ‘significant impact on the number, types and capacity of services available in the communities in which it has been based’. Collaboration between agencies in CFC communities improved in key respects. Between 2006 and 2008, trust and respect between agencies improved and the proportion that worked closely together most of the time rose from 34 per cent to 66 per cent. In the same period, the proportion of agencies that referred clients rose from 86 per cent to 92 per cent and the proportion conducting inter-agency staff training rose from 57 per cent to 73 per cent.

FamilyZone opened in July 2006 after the facilitating partner, the Salvation Army, identified gaps in services for families with preschool-aged children in suburbs surrounding Ingle Farm. FamilyZone offers activities including supported playgroups, parent groups, early learning activities, home visiting, crèche activities, support groups for culturally and linguistically diverse (CALD) families, postnatal support groups, young parent education and support, community events and community engagement initiatives that raise awareness of early childhood issues. A home visiting service engages families identified to be at risk.

An evaluation in 2011 found this provided a vital intake point for parents who may never have engaged support services without it and for whom it built confidence and awareness of options to improve their circumstances. The evaluation also found that FamilyZone improved child health and development; increased parents’ knowledge, competence and family resources; and improved service coordination and access to health, education and other services.

3 ibid., pp. 35, 39.
4 E McInnes & A Diamond, Evaluation of child and family centre: FamilyZone Ingle Farm hub, University of South Australia and The Salvation Army, 2011, pp. 6–12, 15.
THE TARGETED INTERVENTION SERVICE

Families SA funds a family support program, the Targeted Intervention Service (TIS), which is delivered by a number of contracted not-for-profit organisations, including Centacare, Uniting Care Wesley and Aboriginal Family Support Services. It is a non-intensive family support program that can be accessed by families only through a referral from a Families SA case worker. A referral depends on the family being notified, and the notification being screened in and then allocated for a response. Each organisation funded to deliver the program is obliged to report regularly to Families SA against key performance indicators, including numbers of families engaged in the program.

TIS offers support to families at moderate risk for about three hours a week for up to 12 months. An evaluation in 2012 supported TIS, finding that children in the program were less likely to be placed in care than the control group and estimating that it saved about $16.8 million. Yet families must be referred to TIS by Families SA, which in practice requires notifying the Call Centre.

The agencies contracted to Families SA all told the Commission that their service capacity was under-utilised because of poor referral numbers. With the statutory system stretched to the extent that only very high-risk cases are being allocated to caseworkers, few cases appropriate for this less intensive service were available. Centacare and other organisations observed that some referrals to TIS were inappropriate and involved families with far more complex and entrenched problems than the service was designed to address. Referral to a service also depended on Families SA having the capacity to engage with the family to make the referral. In recent times this has been so stretched that Families SA’s ability to perform this referral role has been undermined.

Families SA is aware of these challenges:

Targeted Intervention really relies on the moderate cases to be referred out. There can be high risk cases referred to these programs, but they have to have other services in place, and they have to be willing and voluntary clients. So there are a number of referrals that could be referred out to Targeted intervention, but they are just not making it there. So that has been an issue for these programs for three years that we have been attempting to resolve.

The experience with TIS highlights the need to facilitate access to preventative and early intervention programs from pathways outside the statutory system. Families who can be adequately supported outside the statutory system should be.

GREATER RELIANCE ON SERVICES OUTSIDE THE AGENCY

For many families, Families SA is associated with blame and the removal of children, rather than seen as a place for genuine assistance:

The attitude towards ‘the welfare’ is deep and ingrained and, unfortunately, you can rebadge, you can relocate, you can do all sorts of things, but you will still be ‘the welfare’, the ones who take our kids away, and the degree of trust, zero.

Using not-for-profit agencies and non-statutory government agencies, rather than Families SA, to work with vulnerable families avoids some of that stigma. Families are more willing to accept support and to develop trusting, therapeutic relationships.

Serious child protection notifications continue to require a statutory response by Families SA. These include all Tier 1 and 2 cases and more serious Tier 3 cases, such as the examples of Tier 3 cases given in Chapter 7.

Other government or not-for-profit agencies are better placed to respond to cases that are screened out as NOC, AAR or ROU, as well as some lower risk Tier 3 intakes. In its Intake Review of 20 Tier 3 notifications that were made between 1 July 2014 and 1 December 2014, the Commission identified three less serious notifications to which a support agency could have responded (see Appendix C):

- A mother with two teenage children used to be assaulted by her former boyfriend, including in the presence of her children. On one occasion she was hospitalised as a result. An intervention order was in place, but one of her children was concerned that the mother wanted to reconcile with her boyfriend and the mother confirmed that this was the case.
- The parents had three children, aged from two to 11. The father was an alcoholic and used to physically assault the mother. An intervention order was in place, but both parents had been charged for breaching it. The father had attempted suicide a number of years ago. At the time of the notification, the police had been called to the mother’s home, where the father was present. The mother denied that he had assaulted or threatened her, but they had been arguing and she was concerned because he had been harming himself.
- The mother had two children, aged eight and nine. At the time of the notification, the mother had recently been evicted from accommodation provided by a not-for-profit agency and was staying in emergency accommodation provided by another not-for-profit agency. There was a long child protection history, mainly concerning homelessness as well as the mother suffering serious domestic violence from various partners.
Non-statutory agencies have an opportunity to engage hard-to-reach families simply because they are voluntary services. They have no authority to operate in a mandatory, heavy-handed manner. However, they should be assertive and perseverant. As one witness told the Commission: ‘It’s not a statutory relationship, but it’s a persistent, helping relationship’. They should not simply allow families to drift away.

For harder to engage families, agencies need to invest in service models that are flexible, such as by allowing repeated attendance at a family home and at various times, if necessary. These models aim to remove barriers to engagement and make more difficult any decision by the parents not to engage.

Agencies should have workers who are trained, supervised and supported to not only attend to the needs of parents, but also to keep steadfastly in mind the health, safety and wellbeing of any children in the household. Workers need to be prepared to have difficult conversations with parents about patterns of behaviour that could place children at risk, and about areas of need and how to address these. For example, they should be able to detect signs of potential child trauma and be willing to report back to the Agency if their concerns persist. If concerned about the veracity of a parent’s account of child trauma, they should be assertive enough and adequately resourced to insist on gaining an independent perspective from the child’s doctor, school or childcare centre, or from a relative, friend or neighbours. In short, they should engage the whole family to address the risk to the child.

Importantly, if the family refuses to engage with the support agency or fails to progress therapeutic goals and child safety concerns persist, then the case should be referred back to the Agency for statutory intervention.

DR proposes an alternative response to a statutory response. It allows notifications to be filtered, and the appropriate response determined—whether non-statutory or statutory—according to the level of risk. The rationale for DR is that families are more likely to respond favourably if ‘approached in a non-adversarial, non-accusatory way’. Critically, the access to services delivered through a DR does not depend on an incident-focused investigation, but on a comprehensive assessment of family needs.

There are a number of examples of DR in Australia, and a variety of ways in which notifiers are supported to link families to these diversionary pathways. Each example of DR responds slightly differently to the challenges of increasing referral pathways and the level of services for families in need; however, they have some common features, including:

- customised assessment processes and service procedures;
- the diversion of appropriate families away from a statutory response;
- the encouragement of family cooperation with community-based services;
- family assessment, rather than incident-based investigation; and
- the reduction of the over-representation of some cultural groups in incident-based investigations by improving access to a broad range of services.

The success of a DR system relies on a greater number of intake points and referral pathways, as well as the development of available services. Families who should benefit from this alternative response are those who are unlikely to otherwise attract a service on the basis of risk and/or workload management.

The response to a child’s circumstances that is delivered by the child protection system is generally dictated by the information that is available to the notifier, which is assessed at the system’s entry point. There is no guarantee that what the notifier has seen reflects the child’s experience and what is assessed is the accurate level of risk to the child within the family. The comprehensive assessment of families as part of the referral process is therefore a crucial feature of any differential response.
That is, the accurate level of risk to the child should be identified and the right response chosen:

Child welfare organisations must be able to negotiate the slippery slope that balances family engagement with child protection. Slipping too far to one side relegates us to being a government intervention that can tear families apart in the name of child safety. Too far to the other side, we become a supportive community cushion for needy families that fails to identify children at heightened risk and denigrates our fundamental responsibility to act quickly and definitively to protect them. In this context (differential response) means knowing with reasonable certainty which level of intervention is best for which families, by taking sufficient time at the front end to make the most accurate assessment of both imminent and future risk and by planning interventions best suited for the family’s situation, and by continuing fact finding related to risk factors and protective capacities as long as the family is being served.77

A family that enters the system through an early intervention pathway may later need a statutory response to deal with a newly identified level of risk. Conversely, a family that enters though the statutory pathway may, after investigation, be found to require a less heavy-handed approach. For these reasons, it is critical that any preventative and early intervention pathway has firm connections to the statutory system and enough flexibility to enable the response to change if needed.

In considering referring families to other than a statutory response, it is important to bear in mind that they may move between being in need and at risk, depending on the particular circumstances at the time of assessment. To deal with this, the service response should be flexible and permit referrals between tertiary, secondary and primary systems. It is also highly valuable to capture information from mandatory notifiers (whether by way of report or referral) in a single database. This would mean notifications by referral would be recorded in the C3MS system.

DR is no panacea. While it promises better links to early intervention and remedial services for families who need them, the success of this approach depends on support services being properly resourced to meet the needs of children and families:

If a differentiated response is developed but under-resourced, the families with generic welfare problems will be no better served than they are under current ‘forensic investigation’ models.78

Services need to be coordinated to avoid duplication and gaps in service provision:

The success of a differential model relies, in part, on the creation and development of strong community support agencies that are willing and able to become partners with the state to protect the interests of children. However, collaborations are not always easy to establish and maintain.79

SOUTH AUSTRALIAN DIFFERENTIAL RESPONSE INITIATIVES

LINKING FAMILIES

In June 2015, Families SA introduced Linking Families (LF) to respond to Tier 3 intakes, some lower-risk Tier 2 intakes, and some Adolescent at Risk and Report on Unborn notifications. LF is a phone-based service located at the Families SA Call Centre.80

If LF knows that an existing government or not-for-profit support agency is involved with a family, an LF worker telephones the agency to discuss the new concerns raised in the notification. If the agency is able and willing to address the concerns, it negotiates an action plan with LF, detailing what it will do to address the concerns.81 LF then closes the file.

If LF is not aware that any agency is involved with a family, or where an agency is unable or unwilling to address concerns involving the family, it attempts to contact the parents by letter or, failing that, by telephone. If parents are contacted, an LF worker discusses the concerns with them, with the ultimate aim of referring them to a service provider for support.82

LF is a voluntary process. If parents cannot be contacted by letter or telephone, the case is closed. If they are contacted but refuse to engage, the case is closed. If a support agency accepts the referral, the case is closed on LF’s books, even if the parents refuse to engage with the agency or address the concerns. There is no guarantee that the child will be sighted or spoken to. The matter would return to Families SA only if there was a further notification.83

LF commenced operations on 29 June 2015. In its first six months, LF accepted referrals for 593 children.84 It referred families of 453 of those children (76 per cent) to a service. Families of the remaining 140 children (24 per cent) were not referred to a service. In one of these cases, the support agency did not accept the referral. In every other case, the child’s family declined to be referred, failed to respond or could not be located. Those children received no response.85
The Gateway model, Tasmania

Not-for-profit agencies operate Gateway intake points in four regions of Tasmania. As highly visible entry points to local support services, Gateway accept referrals from vulnerable families, professionals and members of the public. They offer information and advice, assess families’ needs, and refer families to support services as an alternative to the statutory helpline. Each Gateway also has an Integrated Family Support Service (IFSS) that coordinates service provision. Cases requiring only brief intervention are handled by the Gateway, while the IFSS is responsible for cases requiring intensive, longer-term interventions. Each Gateway has a child protection team leader, who serves as a conduit between the diversionary and statutory service systems.1

A review after two years of Gateway’s operation broadly supported the model, finding that it slowed the rate of entry of children into out-of-home care and resulted in many children being referred to family support instead of to the statutory system. Gateway resolved 75 per cent of cases without the need to progress them to family support services, and was described by the review as ‘a clear demonstration of … value for money’.2 The IFSS provided intensive support to 500 more families than forecast over the two years. Interviews with 20 current and past clients showed that they were highly satisfied with the services received and that the services had given them increased confidence in parenting skills and greater family cohesion.3 However, 56.3 per cent of children referred to either Gateway or IFSS experienced subsequent re-notifications. A number of high-risk families who had been historically hard to engage agreed to a collaborative intervention by IFSS and the statutory agency, but, in each case, the families disengaged when the agency closed the case.4

1 Disability and Community Services, Gateway and family support services: Midterm review report, Department of Health and Human Services, Government of Tasmania, February 2012, pp. 17–18, 33, 44.
2 Ibid., p. 33.
3 Ibid., pp. 26, 33–34.
4 Ibid., pp. 22, 26, 33–34.

The Child FIRST model, Victoria

Child FIRST (Family Information Referral and Support Teams) is an intake point operating in 24 subregions in Victoria. It accepts referrals from professionals and members of the public, and focuses on children who are not at risk of significant harm, but whose situations raise ‘significant concerns for their wellbeing’. Child FIRST assesses child wellbeing and family needs, before referring children or families to the appropriate support services or the statutory agency for investigation.

Each subregion is supported by a Child and Family Services Alliance, which consists of a lead community agency and partner service agencies. Each alliance promotes collaborative inter-agency relationships and prepares a three-year plan for improving local service delivery.

An evaluation in 2011 found that Child FIRST and related early intervention initiatives had increased service capacity, visibility and accessibility. Compared with 2005/06 levels, services supported more families and delivered twice as many service hours. They also supported more families with complex problems. The report concluded that the initiatives had moderated growth in child protection notifications and investigations.5

The Family Support Networks model, Western Australia

Family Support Networks (FSNs) are local partnerships between not-for-profit agencies and the Western Australian statutory child protection agency. Each FSN covers a geographical area. In each area, a lead not-for-profit agency manages a common entry point to local secondary services. The lead agency brings together local secondary service ‘partner agencies’, including those who provide intensive family support, counselling, targeted parenting services, homelessness services, domestic violence services, services for young people and targeted community support. The lead agency also establishes strong links to and referral pathways with:

- local universal services, particularly education, health and early childhood services;
- secondary services outside the network, including drug and alcohol, mental health, child and adolescent health, housing support and disability services;
- specialist crisis response and medical services that lie outside the network, but provide key referral options.

Agencies or members of the public generally contact the common entry point by telephone and an initial screening determines if the FSN is the best response for the family’s needs. If so, an assessment officer completes a comprehensive assessment to understand the child’s experiences and developmental progress, any negative patterns or family risk factors, and past involvement with services. Some clients require only a brief intervention, such as the provision of information or limited advice. In other cases, a case plan is developed with the client, which includes goals for an intervention by a partner agency or agencies with the capacity to address the family’s needs. The assessment determines the service intensity. For families with complex or entrenched needs who require a multi-service response, a range of practitioners participates in a multi-agency assessment to plan a coordinated response, with one agency acting as lead case manager.

Agencies in the FSN use the same assessment framework to ensure common language and a consistent approach to risk, needs and strengths. Agencies in the FSN commit to a ‘no wrong door’ philosophy, which means that clients who contact a partner agency but do not require that agency’s service are referred to an appropriate service in the network or to the common entry point for assessment and referral. The emphasis is on supporting clients to access the appropriate service as soon as possible. Clients’ consent is sought for their information to be shared on the FSN database, accessible by all partner agencies.

Each FSN has a child protection leader (CPL), who is engaged by the statutory agency. The CPL helps with decision making about child safety and wellbeing, and also helps the FSN manage risk for children and families. The FSN continues to refer cases that meet the statutory threshold to the statutory agency, but in consultation with the CPL. The CPL develops collaborative relationships between partner agencies and the statutory agency, educates partner agencies and the statutory agency about their respective roles, and improves the two-way referral process between secondary services and the statutory agency.

The FSN model is designed to improve service integration and outcomes for children and families. By providing earlier responses to vulnerable children and families, it aims to reduce referrals to the statutory agency. Other benefits include reducing the need for referrers to maintain relationships with the vast array of secondary services in their area and reducing the need for referrers and clients to make multiple telephone calls seeking a service response.

A 2014 evaluation of one FSN found that notifications to the statutory agency had declined. The FSN provided consistent, strong delivery and allocation of family support services, with promising evidence of improved circumstances for vulnerable children and their families. A cost–benefit analysis indicated that every $1 invested in the FSN produced savings to the government and community of $3.65.

2 ibid., pp. 33–36, 42–43.
3 ibid., pp. 32–34.
4 ibid., pp. 46–47.
5 ibid., pp. 9, 32.
LF records the referral of families to a service, not whether the family actually engages with the service or makes changes that address the concerns. As families involved in the child protection system tend to be difficult to engage, it is likely that these statistics significantly overstate those who meaningfully engaged with services. In cases where LF approached the family of the referred child directly because no service provider was yet involved (273 children), more than half of the families (139 children) did not connect to a service: they declined, failed to respond or could not be located. In other words, when the family, rather than an agency, decided whether the family would be referred to a service, most families declined.

LF will no doubt drastically reduce Closed No Action rates for Tier 2 and 3 intakes in 2015/16. It also provides some response to Adolescent at Risk and Report on Unborn notifications, which historically have received little response. However, this apparent improvement masks the fact that for many children, the response is an offer of services that their parents decline.

LF’s service model is not flexible or assertive enough to respond to families who are resistant to services. There are benefits to using agencies other than Families SA to respond to lower level concerns. However, there should be clear processes to facilitate the flow of information and cases back to the Agency if parents refuse to engage in a way that will secure the health, safety and wellbeing of their children. LF also lacks a structure to coordinate local service provision. If a support service has a concern, its only option is to communicate this back through the Call Centre for fresh triaging. This is not conducive to effective collaboration.

It is also a mistake to engage families directly by telephone. It is notoriously difficult to establish rapport over the telephone, particularly when discussing sensitive matters. Families SA acknowledges these limits by warning workers not to conduct family meetings by telephone:

- The views of all family members cannot be gained, Families SA concerns cannot adequately be explored over the telephone, there is no opportunity to sight the child [and] there is limited opportunity to explore supports/services with the family.96

LF also omits the critical steps of assessing the family’s needs, as well as the health, safety and wellbeing of the children. If these are not properly assessed, services may be mismatched. Some services that LF refers to may be able to do this assessment, but they should be funded and supported to do so, with procedures that make clear this is their role.87

CHILD WELLEING CONSULTANTS AND PRACTITIONERS

From June 2012 to August 2013, Families SA ran a pilot program with one of its experienced social workers working across three primary schools in Adelaide’s northern suburbs as a part-time child wellbeing consultant (CWC).88 School staff, including teachers and counsellors, who were concerned about vulnerable children, could consult the CWC to help assess a family’s level of risk and needs, and consider how the school could better support it. In some cases, the CWC worked with staff to directly support families. The CWC developed partnerships with local services and could recommend services to which staff could refer families. Because staff had an ongoing relationship with families, they could follow up whether parents had engaged with the service and whether the concerns remained.89

The CWC had access to Families SA’s electronic database and shared relevant information about family backgrounds with staff to gain a more complete assessment. If a notification was required, the CWC advised staff about the information needed to make a high quality notification, such as patterns of risk and past attempts to address problems. After a notification had been made, the CWC gave staff feedback about the response Families SA intended to make.90

Over 14 months, 91 families were referred to the CWC. Of these, 62 families were diverted from a notification to the Call Centre, including 47 families who were referred to support services. An evaluation found the program was well received by Families SA and education staff.91

In late 2015, the South Australian Government announced it would employ up to 60 child wellbeing practitioners (CWPs) in a role modelled on that of the CWC, to help staff identify vulnerable children and families and connect them to relevant services. The program will be rolled out in stages, focusing on school sites of vulnerability and need.92

A REFORM MODEL FOR EARLY INTERVENTION AND SERVICE COORDINATION IN SOUTH AUSTRALIA

SELECTION AND FUNDING OF EVIDENCE-BASED SERVICE MODELS

Effective prevention and early intervention depends on a number of key factors, including:

- adequate funding of prevention and early intervention services;
- selecting and funding of appropriate, evidence-based service models;
• robustly identifying vulnerable families, assessing their needs and referring them to evidence-based services; and
• coordinating support services with coherent referral pathways, and committing to share information and promote collaborative practice.

Because resources are finite, they should be devoted to effective programs with a sound evidence base. A bewildering range of programs claim to reduce child maltreatment, including physical and mental health initiatives, home visiting programs, early childhood and preschool education, intensive family support programs, and parenting programs. The outcomes of these programs are difficult to track as they should be measured over a number of years. Programs cross multiple portfolios, including health, education, child protection, disability and community services. They are provided by a variety of government departments and not-for-profit agencies, and funded by a combination of federal, state and local governments, as well as philanthropic sources.93

The potential for silos exists, with individual agencies unaware of evidence concerning alternative service models. Agencies may persist with a familiar service model, even though it is less effective than a potential alternative.

Addressing these challenges requires a process to evaluate available evidence and make funding decisions based on the effectiveness of the various options. Effective service models should be expanded, while less effective ones should be adapted to reflect the best available evidence or lose their funding. It is critical that evaluations collect data on outcomes, not simply activities. In particular, re-notification rates for children in families who have been involved in programs should be carefully monitored.

To meet this need, a cross-departmental Early Intervention Research Directorate (EIRD) should be established in South Australia and located in the Department of the Premier and Cabinet (DPC) or in the office of the proposed Children’s Commissioner, with links to the Child Wellbeing Committee, the function of which is further discussed in Chapter 22. Consideration could also be given to locating it in the research division of the new agency. Every five years, the EIRD should prepare a whole-of-government early intervention strategy to promote the health, safety and wellbeing of children in South Australia. In preparing this strategy, the EIRD would84:

• identify all service model options to address child maltreatment, stretching across government portfolios, government and not-for-profit sectors, programs areas, target populations and settings;
• gather available evidence for those options, including their relative economic performance. Wherever possible, effectiveness should be measured by objective outcomes in reducing child maltreatment, for example, by numbers of child protection reports, substantiations, and entry to or time in out-of-home care; and
• prepare a whole-of-government early intervention strategy, identifying the service models that have sound evidence of their effectiveness in improving children’s health, safety and wellbeing.

The strategy should include service models that respond to the complex, varied needs of families who come to the attention of the child protection system. Particular consideration should be given to service models that are flexible enough to respond to common comorbidities and that are effective at supporting particular subsets of vulnerable parents, such as young people, care leavers, or women who are pregnant for the first time. The strategy should encompass service models that represent early intervention for the benefit of the next generation. In particular, it should consider services that could be delivered from collocated centres, such as Children’s Centres.

The strategy would inform state government funding decisions, and would also form the basis of negotiations with the federal and local governments regarding their funding priorities.

The EIRD should invest resources in robust, independent, outcomes-based evaluations of innovative service models to determine their effectiveness, including their cost, in the South Australian context. Specifically, the Cabinet should direct that South Australian Government agencies that deliver or fund family support services only pursue service models identified in the strategy as effective. Where a sound evidence base is not yet available, a program would need to demonstrate a theory of change, identifying the principles on which the program logic is based. The EIRD should put in place an evaluation framework as a condition of funding such programs. Generally, the results of EIRD evaluations should be made public.

Further, the EIRD should establish research partnerships with universities and research bodies such as the Australian Centre for Child Protection. There is value in establishing a mechanism such as an expert panel, which could be called on to give advice and input at all stages of decision making.

The first step for the EIRD should be to conduct a comprehensive mapping of the available services, their therapeutic objectives and geographical reach.
The Commission is aware of a large-scale project, the SA Early Childhood Data Project, which has been conducted by BetterStart, the University of Adelaide’s Child Health and Development Research Group. The project links administrative data, from areas including child protection, CaFHS, public housing, school enrolments, perinatal records, births and deaths registrations, children’s hospitalisations, National Assessment Program—Literacy and Numeracy (NAPLAN) testing and the Australian Early Development Census, in a way that enables risk factors to be identified and children (tracked through de-identified codes) to be followed over time. It currently provides data from 1999 to 2015, which includes about 300,000 children born from 1999 to 2013.

The Commission understands that the DPC is aware of the project. If the project were supported to provide continuous tracking and linking of the data, it would have the potential to be a powerful tool to inform the work of the EIRD. The Commission supports the investigation of potential links in this regard.

INVESTMENT PRIORITIES

The risk factors for child abuse and neglect are well known. They include domestic violence, parental substance abuse and parental mental health problems, together with housing instability, poverty, low education, social isolation, neighbourhood disadvantage and past trauma. Clearly, not all parents who experience these issues proceed to harm their children; however, they are likely to benefit from additional support to nurture their children.95

It is critical that investment is made in addressing need in families who have identified risk factors, but where no abuse or neglect has yet been identified. Referrals to services should not depend on the existence of a notification to the Agency.

The Commission heard evidence that the prenatal period can be a critical intervention point for parents-to-be—a time when they are more likely to be receptive to services that could help them develop good parenting skills and address factors that might compromise their parenting.

There is also evidence that children who are reported to child protection services for the first time before the age of one year are at greater risk of being reported again. One US study tracked a cohort of children aged under one year who were first reported to child protection services in 2006. Data showed that after five years, 60 per cent of the children who remained living at home after that initial report had been reported again (20 per cent of these had had five or more child protection reports).96

One study used South Australian child protection data for children born in 2001 to examine patterns of repeat involvement in the child protection system. Of one cohort of children who were reported to Families SA in their first year of life, 55 per cent of them went on to be reported five or more times before the age of twelve. Similarly, an examination of children who at the time that they turned 11.5 years who had 10 or more reports made about them, just over half had been first reported to Families SA before the age of two.97

Studies of this kind support the idea that intervention prenatally and in families with infants has the potential to be worthwhile:

There is perhaps no greater opportunity for [Child Protection Services] and other systems to positively intervene than during the first year of life, both because maltreatment that begins during infancy has the potential to become quite chronic in duration and because its timing is developmentally consequential.98

South Australia is well positioned to capitalise on the existing well-developed universal services available at the major birthing hospitals and through the Women’s and Children’s Health Network universal home visiting services. Work is underway to extend the capacity and flexibility of these services to meet the needs of especially vulnerable families, and the Commission also supports continued investment in this regard.

A growth in services for women in the prenatal and immediate postnatal phases should complement the changes to the receipt of, and response to, Report on Unborn notifications recommended in Chapter 7.

Care leavers are identified as more likely to experience the disadvantages that place their children at greater risk of abuse or neglect. For example, they are more likely to experience unstable living arrangements and mental health issues, and to become parents at a young age.99 The state owes a special duty to parents who have a care history, and appropriate services should give priority access to this group. Because of their experiences, care leavers may be at particular risk of disengaging from services. A service designed for this group would need to consider how to overcome that.

CHILD AND FAMILY ASSESSMENT AND REFERRAL NETWORKS FOR SOUTH AUSTRALIA

The South Australian Government should establish child and family assessment and referral networks, which would have the function of coordinating services and be attached to an assessment and referral service, in each region of Greater Adelaide and in the state’s two largest regional areas: Mount Gambier and either Port Augusta or Whyalla. There is value in the alignment of the Families SA hubs geographical boundaries with the boundaries to be serviced, although some flexibility in this regard would be needed to ensure that the services are accessible.
The Commission is not in a position to assess the relative merits of the service designs in operation in other jurisdictions. Therefore, a detailed service model is not prescribed. Further work would be required in the implementation phase to consider what has been learned from the implementation of similar services interstate, and to build on that knowledge and evidence.

Practitioners who are engaged in receiving and assessing notifications in these networks should hold the level of experience and qualifications described in Chapter 7 for Call Centre practitioners. They must also have full access to the Agency’s electronic database.

The assessment and referral service should accept referrals from all sources (including the public). However, if these services were to contribute to the diversion of families from the statutory system, mandatory notifiers would need to be able to discharge their legal obligation by reporting concerns through this alternative route. Legislative amendments would be necessary.

ASSESSMENT, SCREENING AND SERVICE COORDINATION FUNCTION

In each area, a lead not-for-profit agency would be identified to partner with the Agency to:

- manage a local entry point to access services provided by partner agencies in the region;
- coordinate partner agencies that provide services in the region to ensure that referral criteria and procedures complement other services and avoid duplication and service gaps;
- promote, among partner agencies, collaborative practice, information sharing and the use of a common assessment framework; and
- form strong links and referral pathways to local primary services, any secondary services not part of the network (such as statewide health services) and tertiary services (such as the Agency and the hospitals’ Child Protection Services).

The local entry point would screen referrals and provide assessments to determine whether the services available through that point would be the best option to support a family. If so, the entry point would refer the family to a partner agency to provide that support. Where necessary, the entry point would convene a multi-agency assessment meeting with relevant practitioners. A lead case manager would coordinate a multi-service response.

Although there would need to be a flexible approach to what kinds of concerns this early intervention/prevention pathway would deal with, unborn child concerns would be especially suitable. Similarly, notifications about neglect or low-level maltreatment that have the potential to become chronic might be best actioned through this pathway.

Partner agencies should adopt a ‘no wrong door’ approach. If clients contact an agency network member but do not require the services offered by that agency, the agency should refer them to a partner agency who can help them, or to the local entry point for assessment. The emphasis is to provide clients with the support they need, as soon as possible.

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James: A vulnerable child from birth

(The full case study of James is in Volume 2, Case Study 1: James—Vulnerable children, birth to school age.)

James’s mother was 18 years old when he was born. She had a history of abuse and neglect at the hands of her own mother, and had spent time under the guardianship of the Minister. She had unstable living arrangements and little, if any, family support. She was poorly equipped for the challenges of parenting. Her social isolation put James at particular risk.

The Department received the first notification about James before his birth, when a health professional involved in his mother’s care raised concerns. After his birth, further notifications were received from the birthing hospital. Families SA did not conduct an investigation into the notifications on the basis that service referrals had been made for James’s mother.

However, one of the referrals was for a service that turned out not to be available in her residential area. Her engagement with the universal home visiting service was poor and she declined the additional support that would have been available under the extended two-year home visiting scheme. The universal home visiting service was not designed or equipped to deliver the intensive engagement that James’s mother needed.

When James was a little older, Housing SA social workers were aware of Families SA’s early intervention program, the Targeted Intervention Service (TIS), and wanted to refer his mother. They thought she needed the kind of support that TIS would offer. However, when child protection concerns were reported to the Families SA Call Centre, they were not sufficiently serious to justify the allocation of a caseworker, and a referral to the TIS program was therefore not available.

The Commission is not in a position to assess the relative merits of the service designs in operation in other jurisdictions. Therefore, a detailed service model is not prescribed. Further work would be required in the implementation phase to consider what has been learned from the implementation of similar services interstate, and to build on that knowledge and evidence.

Practitioners who are engaged in receiving and assessing notifications in these networks should hold the level of experience and qualifications described in Chapter 7 for Call Centre practitioners. They must also have full access to the Agency’s electronic database.

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Although there would need to be a flexible approach to what kinds of concerns this early intervention/prevention pathway would deal with, unborn child concerns would be especially suitable. Similarly, notifications about neglect or low-level maltreatment that have the potential to become chronic might be best actioned through this pathway.

Partner agencies should adopt a ‘no wrong door’ approach. If clients contact an agency network member but do not require the services offered by that agency, the agency should refer them to a partner agency who can help them, or to the local entry point for assessment. The emphasis is to provide clients with the support they need, as soon as possible.
Each coordination service network would have collocated child protection practitioners who have on-site access to the Agency’s electronic database, to enable the sharing of information with network staff. The practitioners would have clear lines of communication to each local Agency office, so they could provide feedback about particular issues or cases of concern. It would be critical for information about families of concern to flow both from and to the Agency to ensure that children who are at heightened risk are properly responded to.

TRAINING AND CONSULTANCY FUNCTION
As noted in Chapter 7, Figure 7.1, 62 per cent of all notifications to the Families SA Call Centre in 2014/15 came from three mandatory notifier groups: police, education and health. Given this percentage, it would make sense to focus on supporting these groups to refer, rather than notify, appropriate concerns.

Local coordinating service networks should be resourced to provide a consultation service for notifiers who are considering making a referral rather than a notification. Where the level of risk does not justify a notification, notifiers can be supported to make relevant referrals without the involvement of the statutory system.

The assessment and referral service should also develop training and promotional material to highlight the benefits for children of referring for services rather than reporting to the Agency. It is hoped that by engaging at the local level, strategic relationships would be formed and developed between these services and local government services.

A set of accessible referral guidelines would need to be developed to guide notifiers who are considering referring. These guidelines should be available online and in hard copy. Alternatives to notifying would also need to be integrated as a topic into mandatory notification training.

STRATEGIC FUNCTION
In consultation with partner agencies and other primary, secondary and tertiary services, the assessment and referral service would regularly map the needs of vulnerable families and children in its region, with a focus on areas of unmet need and unnecessary or duplicated services. This work would be formalised in an annual Local Assessment of Needs (LAN). Copies of the LAN would be forwarded to the EIRD, the proposed Children’s Commissioner and the Agency. The LAN should inform future funding decisions to ensure regions have the services that they need. The EIRD would provide data to the assessment and referral service to enable it to provide this assessment.

IMPLEMENTATION CONSIDERATIONS
Child and family assessment and referral networks would be a new initiative for South Australia. The Commission recommends that consideration be given to first establishing two pilot programs: one in a metropolitan area and one in a regional area. These pilot programs should be rigorously evaluated before a service model is finalised for implementation across the state.

Figure 8.5: Model of the current child protection system
While it is anticipated that these networks would be developed in partnership with Families SA, they would involve divesting some work that has been the domain of the Agency to not-for-profit organisations. In the early stages of service development and piloting, it may be that the Agency takes a greater role than would be anticipated in the long term.

Because a crucial aspect of the model is that notifiers would be able to satisfy their mandatory obligations by referring to the service, quality screening and assessment would be critical to ensuring that this initiative does not endanger children by responding to their needs in an inappropriate way.

A review of the Victorian Child FIRST model (see box) concluded that it did face some challenges in meeting its aims. In particular, there were concerns about the quality of the casework being delivered, how and where risk was held in the various interconnected organisations, and inconsistent understanding of the threshold for statutory involvement. These are matters that an evaluation would need to closely monitor.

Figure 8.5 is a model of how notifications travel in the current child protection system.

Figure 8.6 illustrates the proposed reform model, with assessment and referral networks assuming prominent roles in providing family support services.

A NEW APPROACH FOR NOTIFIERS
Under the proposed reforms, notifiers with concerns about the safety of children (whether mandated to report or not) would have two options:

1. **Report** to the Agency’s Call Centre in the traditional way.
2. **Refer** to the child and family assessment and referral network where a notifier believes that a child’s circumstances would be adequately attended to by a prevention or early intervention program. This decision should be guided by publicly available referral guidelines, and an awareness program that trains the biggest groups of notifiers in when and how to refer rather than report.
Common Approach

Common Approach was developed for use by practitioners who have regular contact with children and families, but who may not have experience in making formal assessments. It was developed as a result of the National Framework for Protecting Australia’s Children 2009–2020’s first three-year action plan (2009–12) to support cross-agency shared approaches to assessment and referral.

Common Approach consists of an assessment wheel, a questionnaire for young people, a questionnaire for parents and carers, and a guidance manual. The assessment wheel visually represents the various domains of wellbeing (physical health, mental health and emotional wellbeing, relationships, material wellbeing, learning and development, and safety), with concentric circles representing the child, the family and the community. The questionnaires explore these domains in easy-to-understand language.

In 2013, Common Approach was evaluated in four Australian sites, including Northern Connections in South Australia. Common Approach was used in multiple sectors (early childhood, health, schools, mental health, family support and family relationships) and by a wide range of practitioners (counsellors, psychologists, child health and community nurses, teachers, family violence and drug and alcohol workers, youth workers, social workers and childcare centre managers). The evaluation found that Common Approach was a useful tool for practitioners from a range of professions and sectors. It supported relationship building with families and facilitated a more holistic understanding of a family’s strengths, needs and aspirations. Specifically, it encouraged practitioners ‘to identify issues they would not usually identify in their daily practice, leading to more comprehensive referrals, more integrated support and often the earlier identification of problems and difficulties’.

Common Approach avoids clients having to retell their stories to different agencies because they can take their completed assessment wheel to the next agency to which they are referred. The child wellbeing consultant placed in northern suburbs’ schools in 2012 and 2013 encouraged school staff to use Common Approach. She found that it helped staff consider issues beyond the immediate educational setting, such as children’s health and safety and the wider context of family and home life. Workers were also more likely to be ‘on the same page’ about assessments. The expanded program of child wellbeing practitioners in South Australian schools will also use Common Approach.

A report to the Call Centre or a referral to the child and family assessment and referral network would not necessarily determine the approach to be taken to the notification. Notifications could be moved from the report pathway to the refer pathway, and vice versa, via the relationships between the Agency and each child and family assessment and referral network. To avoid double handling and potential miscommunication, calls should be transferred between the network and the Call Centre where appropriate.

Child wellbeing practitioners will offer an additional pathway to some notifiers. This is described below.

CHILD WELLBEING PRACTITIONERS

The initiative to employ child wellbeing practitioners (CWPs) in the Department is excellent. The CWPs will offer Department staff support and guidance when they are assessing the needs of children and families, and will help them to consider relevant, accessible support options in the Department and elsewhere.

Child protection concerns are greater in certain regions of Adelaide and South Australia. The Department should place most CWPs in these regions. However, all Department staff should have access to a CWP, at least by telephone. This might be achieved by having a CWP in each education local partnership, or by establishing a central unit of CWPs to service staff who do not have an access to a local CWP.

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The initiative to employ child wellbeing practitioners (CWPs) in the Department is excellent. The CWPs will offer Department staff support and guidance when they are assessing the needs of children and families, and will help them to consider relevant, accessible support options in the Department and elsewhere.

Child protection concerns are greater in certain regions of Adelaide and South Australia. The Department should place most CWPs in these regions. However, all Department staff should have access to a CWP, at least by telephone. This might be achieved by having a CWP in each education local partnership, or by establishing a central unit of CWPs to service staff who do not have an access to a local CWP.
on-site CWP. The CWPs should be able to provide advice and referral information to school staff, but also engage directly with families whose children have been identified as at risk. To avoid double handling, mandatory notifiers who work in the schools or local partnerships to which a CWP is attached, should be able to discharge their duty to notify by making a report to a CWP, where the CWP agrees that the matter is appropriate for a referral to a child and family assessment referral network.

CWPs should have on-site access to the Agency’s electronic database to enable them to record notifications that are diverted to the child and family assessment and referral network, and also share information with school staff. They should have clear lines of communication to the local office of the Agency so that they can provide feedback about particular issues or cases of concern. Information about families of concern must flow both from and to notifiers in government agencies.

CWPs will have a complex, challenging role. They will serve as local child protection experts and it is intended that their knowledge and views will shape school staff. They have the potential to reinforce either good or poor professional judgement. For this reason, they should be familiar with current child protection research, including child development research and the impact of different types of abuse and neglect. They should also be experienced in assessing family needs and child safety and wellbeing.

With this in mind, CWPs should be experienced social workers. However, in some cases, it will be appropriate to recruit experienced professionals with other degree-level, tertiary qualifications, such as teachers or nurses, provided they have completed additional child protection training or have the necessary experience in the field.

CHILD WELLBEING ASSISTANTS
A range of state government agencies, including SA Health and SAPOL, have frequent contact with vulnerable children and families, as do many non-government organisations, such as independent schools, community health clinics, general practitioners and not-for-profit family support services.

These organisations should consider how they can better help their staff to make appropriate assessments and to refer vulnerable families for support. In particular, they should consider nominating an existing employee at each site to serve as a child wellbeing assistant (CWA) in addition to their usual role. The appointment of child and family sensitive practice champions in Drug and Alcohol Services South Australia is an example of a similar concept. CWAs should receive training in relation to issues such as child development and the impact of abuse and neglect, and about support services in the local area. They could provide advice and guidance to staff in their organisation about options to support vulnerable families. Mandatory notifiers would not be able to discharge their obligations by a report to a CWA.

The Agency should convene regular cross-agency training and networking sessions for all CWAs in different regions of Adelaide or South Australia. These sessions should be seen as vital opportunities to increase the knowledge of CWAs and to encourage local inter-agency support and collaboration. There may also be opportunities for CWAs to develop links at the local level with staff from child and family assessment and referral networks.

The South Australian Government should select and fund a simple, common assessment framework, such as the Common Approach (see box), which is suitable for use by a wide range of professionals who work with vulnerable children and families. The framework should be used by government and not-for-profit services providing primary and secondary child protection services to encourage early identification of problems and more comprehensive referrals. It could also improve understanding between agencies about assessment issues and reduce the number of times that clients have to retell their stories.
The Commission recommends that the South Australian Government:

49 Institute longer term funding arrangements for prevention and early intervention services, subject to evaluation and performance criteria.

50 Establish an Early Intervention Research Directorate (EIRD) to:

a prepare a Prevention and Early Intervention Strategy that is updated at least every five years:

i to identify service models that have proved effective or show promise in promoting the health, safety and wellbeing of children in South Australia;

ii to serve as the basis of decisions by South Australian Government agencies to fund prevention and early intervention services;

iii to form the basis of negotiations with the federal and local governments, with a view to coordinating funding priorities;

b establish research partnerships and fund evaluations of innovative service models to determine their effectiveness and value for money; and

c focus on the prevention and early intervention investment priorities identified in this report.

51 Establish child and family assessment and referral networks in each region of Greater Adelaide and regional South Australia that include:

a a lead not-for-profit agency to manage, in partnership with the Agency, a local entry point to services provided by partner agencies in the region, focusing on collaborative practice and coordinated, multi-service responses, when required;

b an annual Local Assessment of Needs (LAN) prepared by the lead not-for-profit agency after mapping the needs of vulnerable families and children in each region. The LAN would inform funding decisions for services; and

c child protection practitioners in each child and family assessment and referral network to support decision making in relation to child safety including when to refer higher risk families for a statutory response by the Agency.

52 Employ qualified child wellbeing practitioners (CWPs) accessible to all staff in the Department, but focusing on locations of greatest need, to consult with staff and to work directly with vulnerable families. CWPs should have on-site access to the Agency’s electronic database.

53 Equip relevant government agencies to support vulnerable families by appointing existing employees as child wellbeing assistants (CWAs), in addition to their usual role, to provide staff guidance about options to support vulnerable families.

54 Implement a simple, common assessment framework, such as Common Approach, for use by government and not-for-profit services who work with vulnerable children and families.

55 Convene regular cross-agency training and networking sessions for all CWPs and CWAs in each local metropolitan and country region to increase their knowledge and support local inter-agency collaboration.

56 Amend the Children’s Protection Act 1993 to permit mandated notifiers to discharge their obligations by: reporting to the Agency’s Call Centre (Child Abuse Report Line); or to designated child wellbeing practitioners, or by referral to a child and family assessment and referral network where the notifier believes a child’s circumstances would be adequately attended to by a prevention or early intervention program.
Some oral evidence, witness statements and submissions were received on a confidential basis. The source is known to the Commission, and is identified by a number in the endnotes.
8 EARLY INTERVENTION

NOTES


47 Oral evidence: P Strachan.


49 Oral evidence: D Jeffs; Name withheld (W56); P Strachan. Witness statements: Name withheld (S68); L Williamson, Department for Education and Child Development (DECD), StrongStart: Information sheet for service providers, Government of South Australia, no date; Fraser Mustard Centre, StrongStart—Northern pilot: Evaluation report, prepared for DECD, December 2015. StrongStart is a new program and the evaluation is designed to inform its future delivery.

50 OECD, Integrating social services for vulnerable groups, p. 12.

51 Oral evidence: P Sandeman.

52 Oral evidence: J Brown; M Gillissen; name withheld (W85). Submission: S Dunstan, name withheld (S105); J Walker.

53 Oral evidence: Name withheld (W56); P Strachan. Witness statement: Name withheld (S68), DECD, StrongStart: Information sheet; Fraser Mustard Centre, StrongStart—northern pilot.

54 Oral evidence: D Jeffs; P Strachan. Witness statements: Name withheld (S68); L Williamson. Fraser Mustard Centre, StrongStart—Northern pilot, p. 42.


58 L Bromfield et al., Issues for the safety and wellbeing of children, p. 15.

59 Oral evidence: H Lockwood. Also oral evidence: Name withheld (W105). OECD, Integrating social services for vulnerable groups, pp. 31–32.

60 Screened-in notifications include Tier 1, Tier 2 and Tier 3 matters, but not extra-familial matters, which are referred to South Australian Police.


62 Families SA, ‘Child protection manual of practice: Vol. 1’, internal unpublished document, 2010, pp. 142–143, 146. Yaitya Tirimangakitti, the unit at the Call Centre formerly dedicated to Aboriginal and Torres Strait Islander children, could recommend a home visit.

63 RA Layton (Chair), Our best investment, p. 9.41; Case 209 review cited in submission: Child Death and Serious Injury Review Committee.


66 Oral evidence: S Williams & W Guppy; K Drew; A Pavy; P Munro & E Ward.


68 Oral evidence: Name withheld (W105).


70 Oral evidence: Name withheld (W105).

71 Either by the consent of parents or in accordance with proposed legislative amendments to facilitate information sharing, set out in Chapter 21.

72 Also referred to as ‘dual track’, ‘multiple track’ or ‘alternative response’.


79 ibid., p. 15.

80 Families SA, ‘Linking Families procedure’, draft internal document, Government of South Australia, 2015, pp. 4–7; Families SA, ‘Call Centre business case’, internal unpublished document, 2014, pp. 23, 31. Notifications that relate to an open case are still sent to the relevant Assessment and Support team. Tier 3 cases relating to Aboriginal children are sent to an Aboriginal Services team.


82 ibid., pp. 10.

83 ibid., pp. 9–12.

84 Data provided by Families SA. Referrals accepted include cases referred to Linking Families but exclude files closed due to an escalation of risk or not allocated because they did not meet the criteria or were re-assessed and screened out.

85 Data provided by Families SA. The families of four children (1 per cent) had not yet received an outcome from Linking Families.


87 Oral evidence: K Drew.
The schools were located in particularly disadvantaged communities who experience high levels of poverty, poor mental health, low socio-economic status, substance misuse and family violence.

Oral evidence: Name withheld (W102).


ibid.


L Segal et al., Where to invest to reduce child maltreatment, p. 2.

Submission: Anglicare. L Segal et al., Where to invest to reduce child maltreatment, pp. 4–5.

L Bromfield et al., Issues for the safety and wellbeing of children, p. 1.


F Arney, email to the Child Protection Systems Royal Commission, 5 May 2016.


Morgan Disney & Associates et al., Transition from care: Avoidable costs to governments of alternative pathways of young people exiting the formal child protection care system in Australia, report for the Department of Families, Community Services and Indigenous Affairs, November 2006.

B Lonne et al., ‘Victoria’s Child FIRST and IFS differential response system’, p. 43.


South Australian public schools are divided into 60 local partnerships.

Some oral evidence, witness statements and submissions were received on a confidential basis. The source is known to the Commission, and is identified by a number in the endnotes.
## INTERVENTION WHERE THERE IS IMMINENT RISK

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OVERVIEW

Working with families who come into contact with the child protection system requires persistence and skill to engage them about issues that can be traumatic and shameful. It requires presence of mind not to lose sight of the child in the midst of family interventions. While it might seem axiomatic that children’s interests lie at the heart of child protection interventions, in practice the needs and anxieties of parents, practitioners and other adults too easily subsume those of the children on whom they should be focused.

This chapter discusses the Agency’s response to suspected child abuse or neglect. It examines the assessment process and the statutory powers that facilitate its response. It builds on the preceding chapter by detailing circumstances in which agencies other than Families SA (the Agency) should respond to low-risk cases of suspected abuse or neglect, while affirming the need for the Agency to respond to cases involving moderate to high risk to children. It highlights the poor responses that the Agency presently delivers in many serious cases of child maltreatment.

The chapter also discusses the family preservation services offered to families at imminent risk of having their children removed, and emphasises the need for purposeful interventions that do not permit children to remain for prolonged periods in unsafe situations. It considers options for the early use of formal but voluntary interventions, including a refocusing of Family Care Meetings. It looks at the process of removing children, where necessary, from their parents’ care and of obtaining orders from the court to secure children’s care.

Options to support families to resume the care of their children after removal are also discussed. The chapter argues for clear timeframes to meet children’s need for stability and permanence either by returning promptly to their parents’ care or by being supported in a stable, long-term alternative care placement. It discusses how contact arrangements can support children’s broader case plans.

This chapter principally relates to the Commission’s Terms of Reference 5(a) to 5(c), in the context of Terms of Reference 1 to 4.

POWERS FOR ASSESSING AND INTERVENING IN FAMILIES

The Children’s Protection Act 1993 (SA) (the Act) provides that where the Department’s Chief Executive ‘suspects on reasonable grounds that a child is at risk’ and ‘believes that the matters causing the child to be at risk are not being adequately addressed’, he or she:

Must cause an assessment of, or investigation into, the circumstances of the child to be carried out or must effect an alternative response which more appropriately addresses the potential or actual risk to the child.

Effective assessment depends on practitioners having access to as much information as possible about the circumstances of children and parents in a family. Many families cooperate with assessments, and consent to information being obtained from other sources. Family members may also consent to undertake specialist assessments, such as for substance abuse or mental health.

Matters covered in an assessment are personal and potentially shaming. Some parents, including former children in care who have painful memories of the child protection system, have had poor experiences with government authorities. Not surprisingly, some families are unwilling to cooperate with Families SA. Where families are not cooperative, Families SA requires the cooperation of other agencies or the use of statutory powers or court orders (or a combination of these) to facilitate the information gathering that is critical to good assessment.

COOPERATIVE INFORMATION SHARING

The Information Sharing Guidelines (ISGs) are a ‘statewide policy framework for appropriate information sharing practice’. The ISGs apply to most South Australian Government agencies and to non-government organisations contracted by the government to provide services. The ISGs encourage agencies to share information where ‘a person is at risk of harm (from others or as a result of their own actions) and adverse outcomes can be expected unless appropriate services are provided’. Chapter 21 outlines significant barriers that impede their effective operation. As a result, relevant information is not always forthcoming.
STATUTORY POWERS

Families SA has the power to require, by notice in writing, any person (or the agency that he or she works for) ‘who has examined, assessed, carried out tests on or treated the child’ to produce a written report concerning the examination, assessment, test or treatment. This power is effectively limited to information from health providers directly pertaining to the child. Information from other sources or relating to a child’s parents (including their drug and alcohol use, mental health or history of domestic violence) requires a court order.

To assist child protection investigations, authorised police officers have powers of entry, search and seizure, and to require a person to answer questions. These powers must usually be authorised by warrant issued by a magistrate. Families SA and South Australia Police have agreed to confine requests for the use of these powers to matters of sexual abuse, serious neglect, physical abuse or the death of a child. In practice, Families SA rarely calls on these powers, preferring instead to seek orders from the Youth Court.

COURT ORDERS FOR INVESTIGATION AND ASSESSMENT

The Department’s Chief Executive can apply to the Youth Court for investigation and assessment orders if he or she is of the opinion that:

• there is information or evidence leading to a reasonable suspicion that a child is at risk;
• further investigation of the matters is warranted or a Family Care Meeting should be held; and
• the investigation cannot ‘properly proceed’ without an order or the child needs to be protected while the matter is investigated or a Family Care Meeting is held.

If satisfied that there are sufficient grounds and that it is in the child’s best interests, the court may make orders, including:

• authorising the examination and assessment of the child. For example, this power may authorise forensic medical assessments of children who may have been abused;
• authorising or directing the assessment of a parent, guardian or carer to determine their capacity to care for and protect the child. This power may be used to direct a parent to undergo a drug and alcohol, mental health or parenting assessment;
• authorising Families SA to require any person to answer questions to the best of the person’s knowledge, information or belief. This power may be used to obtain a parent’s history of criminal offending or a child’s school attendance records;
• authorising Families SA to require any person (or the agency he or she works for) who has examined, assessed or treated a party to the proceedings (other than the child) to provide a written report of the examination, assessment or treatment. This power may be used to access a parent’s drug and alcohol or mental health treatment records; and
• placing the child in the custody of the Minister.

These orders last up to 42 days, and can be extended for a further 28 days. If Families SA decides that a child should remain in the Minister’s custody after this period, it must apply for care and protection orders, which last up to 12 months or until the child turns 18 years.

POWERS TO IMPROVE INFORMATION GATHERING

Without a court order, Families SA’s information-gathering powers are confined to requesting a written report from health providers who have assessed the child. It cannot access information from non-health sources, such as a child’s school, childcare centre or playgroup, or about a child’s parents, such as their criminal history. Nor can it seek information from the parents’ landlord or mental health, drug and alcohol, or domestic violence worker.

In many cases, the only way for Families SA to obtain information of this sort is to apply for an order in the Youth Court. That application is almost invariably accompanied by an application for a custody order, a significant escalation in any intervention. The court process is adversarial. It requires parents to attend court, often with legal representation. It documents concerns in a ‘concise and … collected fashion’ which can be damaging to parents struggling with poor self-esteem, and can ‘get in the way of therapeutic involvement’.

In practice, proceedings for investigation and assessment orders are rarely contested; if they are, the contest concerns the custody order, not the orders to access information.

Information produced as a result of a court order comes late in the intervention. Broadening the Agency’s information gathering powers would permit earlier access to information concerning risks to children and the capacity of their parents. This could result in earlier, more comprehensive assessments of child safety and parental need, and better targeted support for parents. While some cases may still require a court process, increasing the Agency’s powers would avoid prematurely sending parties to Court.

Widening these powers would bring South Australia into line with most other Australian jurisdictions. Table 9.1 summarises the information gathering powers of statutory child protection agencies in Australia.
Table 9.1: Information the statutory agency can require without a court order, by jurisdiction

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<tr>
<th>JURISDICTION</th>
<th>LEGISLATIVE PROVISION</th>
<th>TYPE OF INFORMATION</th>
<th>INFORMATION PROVIDER</th>
<th>POLICE</th>
<th>SCHOOL</th>
<th>PUBLIC HOSPITAL</th>
<th>GP</th>
<th>FAMILY MEMBER</th>
<th>OTHER</th>
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<td>Australian Capital Territory</td>
<td>Children and Young People Act 2008, sections 858, 859, 862.</td>
<td>Information relevant to the health, safety or wellbeing of a child, including his or her family or someone else.</td>
<td>Parent, someone with parental responsibility or out-of-home carer.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
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<tr>
<td>New South Wales</td>
<td>Children and Young Persons (Care and Protection) Act 1998, section 248.</td>
<td>Information relating to the safety, welfare or wellbeing of a child or class of children.</td>
<td>TAFE, prescribed organisation, public health organisation, private health facility.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td></td>
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<tr>
<td>Northern Territory</td>
<td>Care and Protection of Children Act 2007, section 34.</td>
<td>Information about the child or another relevant person (for example, a family member of the child).</td>
<td>‘Person reasonably believed to have specified information’, person employed by a government agency, operator of child-related services, health practitioner.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Queensland</td>
<td>Child Protection Act 1999, sections 159C, 159D, 159N</td>
<td>Information to help investigate alleged harm or risk of harm to a child or to help decide the need for protection, including information about the child’s family or someone else.</td>
<td>Chief executive of adult corrections, community, disability, education, housing and public health services, or any prescribed entity that provides a service to children or families. Person in charge of a student hostel.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
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<td>State</td>
<td>Act</td>
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<td>Mandated Notifiers</td>
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<td>South Australia</td>
<td><em>Children's Protection Act 1993,</em> section 19(2).</td>
<td>Written report on the examination, assessment, tests or treatment of a child.</td>
<td>‘Person who has examined, assessed, carried out tests on or treated the child.’</td>
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<tr>
<td>Tasmania</td>
<td><em>Children, Young Persons and Their Families Act 1997,</em> section 18.</td>
<td>Report concerning a child, guardian, significant person, person with whom the child resides.</td>
<td>Person who has examined, assessed, carried out tests on or treated the child or who may have information relevant to the child’s safety, welfare or wellbeing.</td>
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<tr>
<td>Tasmania</td>
<td><em>Children, Young Persons and Their Families Act 1997,</em> section 53B.</td>
<td>Information concerning the safety, welfare or wellbeing of a ‘relevant person’, which includes a person in respect of whom: the Secretary or a community-based intake service has received information under the Act, or an assessment or care and protection order is in force.</td>
<td>Mandated notifiers, state service officer or employee employed in a government department or state authority, manager of a private medical establishment; controlling authority of an approved hospital, approved assessment centre or secure mental health unit; person in charge of a disability services provider funded to provide specialist disability services to a child; person in charge of an organisation funded by the Secretary to provide drug and alcohol treatment services; person in charge of an organisation that receives a referral from the Secretary or a community-based intake service.</td>
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<tr>
<td>Victoria</td>
<td><em>Child, Youth and Families Act 2005,</em> sections 192, 196.</td>
<td>None</td>
<td>N/a</td>
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<td>Western Australia</td>
<td><em>Children and Community Services Act 2004,</em> sections 23, 24A.</td>
<td>None</td>
<td>N/a</td>
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Victoria and Western Australian legislation permits, but does not require, a range of information holders to share relevant information with the statutory agency. In Victoria, the statutory agency may require certain people to provide information in relation to a child who is under a protection order. All other jurisdictions in Australia give their respective statutory agencies considerably wider powers than South Australia to require access to information.

Chapter 21 recommends legislative changes in this state to clarify the duty of a range of agencies to share information relating to the health, safety and wellbeing of children. To complement this scheme, the power of the Agency to require other agencies to provide information should be broadened. The Agency should have the power to require information relating to the health, safety and wellbeing of a child, including information relating to other people (in particular the child’s parents or caregivers), where this is relevant to a child’s health, safety or wellbeing. Families SA should be able to require this information from all government, for-profit and not-for-profit agencies that provide services to children and young people and their families, including those organisations in health, education, policing, juvenile justice, disability, housing, mental health, family violence, drug and alcohol services, community services, multicultural services, correctional services and the screening unit. Information should be provided promptly; and within 24 hours if the Agency advises that it is an emergency.

RESPONDING TO ALLEGED ABUSE OR NEGLECT

As discussed in Chapter 7, the Families SA Call Centre (the Call Centre) applies a response priority rating (Tier 1, 2 or 3) to screened-in child protection notifications. The tier rating determines not only how quickly Families SA should respond, but also the nature of that response.

INVESTIGATIVE RESPONSE FOR TIER 1 AND 2 MATTERS

Tier 1 receives the highest priority. The Call Centre refers Tier 1 and 2 intakes to a Families SA Assessment and Support team for an investigative response. Under Families SA policy, the response must begin within 24 hours for Tier 1 cases and between three to 10 days for Tier 2 cases. The nature of the investigative response depends on the concerns being examined, and includes elements of investigation and assessment:

Investigation encompasses the efforts to determine if abuse or neglect has occurred. Assessment goes beyond this concept to evaluate a child’s needs, safety and risk, the family situation and environmental context, and to determine whether and what services are needed to ameliorate or prevent child abuse and neglect, or to respond to the child’s needs.

More chronic cases, such as a child who is frequently absent from school and, when he does attend, is dishevelled and hungry, tend to call for an assessment. In these cases, it is more important to determine the circumstances that are preventing the family from meeting the child’s needs than identifying the specific school absences or incidents of hunger. More acute cases, such as a head injury, need an investigation to determine the circumstances surrounding the particular incident. However, an investigation is usually complemented by a broader assessment of the child’s and the family’s circumstances.

There is no clear delineation between assessment and investigation. Rather, they represent a continuum. Except where it is otherwise expressed, this report uses ‘the assessment process’ to encompass both investigation and assessment.

STRATEGY DISCUSSIONS

Strategy Discussions help agencies coordinate responsibilities during the assessment process. They should generally be held in Tier 1 cases and, if an agency considers it necessary, in Tier 2 cases. Families SA generally convenes the meeting and invites representatives from Families SA, SA Police and Child Protection Services. Attendees must be sufficiently senior to plan the response and commit resources. Meetings may be in person or by teleconference. They canvass information known about a family, decide the immediate response and develop a coordinated investigation plan. Strategy Discussions can produce good outcomes by encouraging information sharing and coordinating responses. However, limited resources mean that Families SA practitioners do not always attend, or appear rushed and poorly prepared when they do. This can waste time and result in inaccurate information being shared.

A prompt Strategy Discussion is crucial in cases of suspected physical trauma, where Families SA support is needed to facilitate a forensic medical assessment. Yet Families SA’s response is often slow and its after-hours Crisis Care response unit sometimes refuses to convene Strategy Discussions outside business hours. This risks the loss of crucial evidence.

Strategy Discussions should be held without delay when children present with physical injury. More generally, the Agency should support practitioners to give Strategy Discussions the focus that they deserve: to convene them promptly, to attend thoroughly prepared and, when required, to re-convene the meeting at appropriate stages during the assessment process.
While Strategy Discussions can include other government and non-government agencies, at present, they are invited only sporadically. These other agencies often have much to contribute to Strategy Discussions. Families SA should train and support its practitioners to invite additional agencies in appropriate cases.

The Interagency Code of Practice: Investigation of Suspected Child Abuse or Neglect (ICP) is the guiding document not only for Strategy Discussions, but also for broader inter-agency collaboration in the investigation of suspected child abuse or neglect in South Australia. An updated ICP, due to be released in July 2016, is a significant improvement in a number of respects. Where the previous version was weighted towards sexual abuse, the revised version addresses all forms of abuse and neglect. The revised version will apply not only to government agencies, but also to non-government agencies that provide relevant services.

Collaboration is important throughout the assessment process. The revised ICP encourages Families SA to act as lead agency and to coordinate service provision with other agencies throughout the assessment process. To this end, not-for-profit agencies funded to provide family support services are being trained in SBC.27 To this end, not-for-profit agencies funded to provide family support services are being trained in SBC.27

ASSESSMENT TRAINING
Families SA practitioners are guided in the assessment process by the practice framework, Solution Based Casework™ (SBC). The framework aims to improve consistency through providing a ‘common conceptual map’ for practitioners in Families SA and its partner agencies.27 To this end, not-for-profit agencies funded to provide family support services are being trained in SBC.27

SBC does not purport to be a complete statement of all that child protection practitioners need to know. For example, it does not provide specific criteria for decisions about risk. Rather, it gives a structure in which professional judgement can occur.28 Moreover, while SBC offers knowledge on how to do an assessment, it cannot supply the experience that leads to practice wisdom: ‘You can have the knowledge, but if you ... don’t have a base to build it from, then it doesn’t have as much meaning’.29 This calls for broader training and ongoing clinical supervision.

As outlined in Chapter 5, the rollout of SBC training beginning in mid-2013 was truncated. Many Families SA practitioners are not accredited in SBC more than two years after its introduction. Families SA also froze all non-SBC training offered by its Learning and Practice Development Unit during the initial SBC rollout. In this period, practitioners lacked both adequate SBC training and alternative training in areas such as orientation to child protection or court work.30 Given the accepted limitations of SBC, this was a serious error that had a disproportionate impact on assessment and support practitioners, a high proportion of whom are recent graduates. This is most unfortunate given the particular complexities of assessment and support work and the widely accepted need for ongoing, high-quality training, particularly for recent graduates.

The ‘rule of optimism’ describes the tendency of practitioners to sometimes reduce, minimise or remove concerns for a child’s welfare or safety ‘by applying overly positive interpretations to the cases they were assessing’.31 This tendency can result in children being left in situations of significant danger and experiencing prolonged trauma.

There is a risk that practitioners using SBC are overly optimistic when working with families. However, SBC should make it difficult for practitioners to minimise a family’s problems. Practitioners are encouraged to gather details of problems and to identify how they arise in the life of a family. They are urged not to accept at face value what parents say, but to seek a variety of sources of evidence and to use ‘straight talk’32 to confront problems as they really are.33 However, less confident practitioners or those with cursory exposure to SBC training who have not yet applied their knowledge in practice under clinical supervision may bring insufficient rigour to assessments and lose focus on the child.34

CONFLICTING PRACTICE REQUIREMENTS
In addition to SBC, an Assessment Framework helps practitioners to assess the needs of children, families and carers through different stages of contact with Families SA. The framework contains developmental domains, principles of assessment and theoretical perspectives for practitioners as a ‘consistent method of gathering, organising and interpreting information to better understand a child and their world’.35 Practitioners must also use a series of decision-making tools that contain questions to guide assessments of risk and safety. These tools help practitioners to make these ‘critical decisions with increased validity, reliability and consistency, and, importantly, to target scarce resources to those children and families at highest risk’.36

The principles underlying SBC, the Assessment Framework and the decision-making tools are similar, but they use different language. Further, practitioners must complete three sets of documentation that require different information: SBC; C3MS, Families SA’s electronic case management system; and the decision-making tools. The work to reconcile and integrate this documentation remains incomplete.37

These requirements unnecessarily burden practitioners and are liable to cause confusion and inconsistent practice. As a priority, policies, procedures and pro forma documentation in this area should be rationalised.
SUBSTANTIATION
At the end of an investigation, the practitioner (in consultation with the supervisor) decides whether abuse or neglect has occurred and records this decision, which is known as ‘substantiation’. Substantiation is a professional judgment that must be supported by sound rationale based on the information gathered. It does not need to be to the criminal standard of ‘beyond reasonable doubt’.

Table 9.2 compares the proportion of screened-in notifications that are investigated and subsequently substantiated.

Relatively few screened-in notifications are substantiated. Table 9.3 shows this is the case throughout Australia, although the rates vary significantly.

The significance of substantiation should not be overstated. Plainly, maltreatment does not occur only in cases where abuse or neglect is substantiated. This is for a number of reasons, which include that:

• the case may not be investigated or may be poorly investigated, including due to a lack of agency resources;

• there may be a differential response (see Chapter 8), which does not aim to establish whether maltreatment occurred; or

• there may be insufficient evidence of maltreatment or harm, particularly in cases involving young children.

Moreover, substantiation is not a strong predictor of risk of future maltreatment or other developmental harm. Future risk is similar in substantiated and non-substantiated cases.

SAFETY AND RISK ASSESSMENTS
Separate to whether abuse or neglect is substantiated, Families SA practitioners complete safety and risk assessments. Safety assessments focus on present danger and immediate interventions needed to protect the child. In cases where abuse or neglect is substantiated, practitioners complete risk assessments to examine the likelihood of future maltreatment and whether ongoing services are needed.

Table 9.2: Screened-in notifications investigated and substantiated, 2011/12 to 2014/15

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screened-in notifications</td>
<td>17,290</td>
<td>16,947</td>
<td>16,932</td>
<td>19,160</td>
</tr>
<tr>
<td>Investigated (% of total)</td>
<td>5082 (29%)</td>
<td>5333 (31%)</td>
<td>6541 (39%)</td>
<td>5519 (29%)</td>
</tr>
<tr>
<td>Substantiated (% of total)</td>
<td>2139 (12%)</td>
<td>2221 (13%)</td>
<td>2739 (16%)</td>
<td>2335 (12%)</td>
</tr>
</tbody>
</table>

Note: Screened-in notifications include those assessed as Tier 1, 2 or 3, but exclude extra-familial matters, which are referred to SA Police. Source: Data provided by Families SA.

Table 9.3: Notifications and substantiations by state and territory, 2014/15

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>VIC</th>
<th>QLD</th>
<th>WA</th>
<th>SA</th>
<th>TAS</th>
<th>ACT</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notifications</td>
<td>126,146</td>
<td>91,586</td>
<td>22,350</td>
<td>16,828</td>
<td>22,040</td>
<td>13,560</td>
<td>10,633</td>
<td>17,026</td>
</tr>
<tr>
<td>Substantiations (% of total)</td>
<td>26,424 (21%)</td>
<td>14,115 (15%)</td>
<td>6435 (29%)</td>
<td>3623 (22%)</td>
<td>2335 (11%)</td>
<td>904 (7%)</td>
<td>595 (6%)</td>
<td>1992 (12%)</td>
</tr>
</tbody>
</table>

Note: This data should be read with caution as counting rules vary between jurisdictions. It excludes notifications that the relevant statutory agencies screen out as not meeting the threshold for a child protection notification. Notifications for South Australia in this table vary from data elsewhere in this report because they include extra-familial matters that Families SA refers to SA Police and that the Commission otherwise excludes as screened-in notifications.

SAFETY ASSESSMENTS
Practitioners complete a safety assessment immediately after the first face-to-face contact with the family. Subsequent safety assessments occur during the life of a case, including if there is change in the family's circumstances or if safety interventions are not working. A safety assessment also occurs before the child returns home and before the case is closed.43

Practitioners use a safety assessment decision-making tool to identify threats that could place the child in imminent danger of serious harm and potential responses to mitigate the danger. The following responses are listed in order of escalation:

1 Family, neighbours or other individuals are used as safety resources.
2 Community agencies or services are used as safety resources.
3 The alleged perpetrator leaves the home, either voluntarily or with legal action.
4 The non-maltreating caregiver moves with the child to a safe environment.
5 The child is placed outside the home by a voluntary placement with extended family.
6 The child is placed in foster care under a parental authorisation.
7 The child is placed in foster care under a Voluntary Custody Agreement.44
8 The child is removed under section 16 of the Children's Protection Act.

If a child needs to be removed (points 6 to 8 above), the practitioner must record why less intrusive responses would not have been appropriate.45

If the safety assessment identifies threats that could be managed, allowing the child to remain safely at home, the practitioner completes a safety plan. Safety plans should list short-term interventions and last for up to 30 days. They should list clear behavioural goals with short timeframes, so the parties are clear about the respective obligations of the parents and Families SA. Longer-term interventions should be recorded in a child’s case plan.46

There are mandatory overrides for situations that Families SA determines warrant the highest level of service, regardless of risk score. A discretionary override allows practitioners (with approval of the supervisor) to increase the risk level set by the tool.46

The risk assessment tool ranks cases according to risk, but does not dictate what level of service cases should receive. Families SA policy states how the tool’s ratings should be applied to manage workload: to determine when to close files and how much service to provide.49 Table 9.4 shows how the assessment of risk determines the level of service.

<table>
<thead>
<tr>
<th>RISK LEVEL</th>
<th>OPEN CASE</th>
<th>MONTHLY FACE-TO-FACE CONTACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very high</td>
<td>Yes</td>
<td>4</td>
</tr>
<tr>
<td>High</td>
<td>Yes</td>
<td>3</td>
</tr>
<tr>
<td>Moderate</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>Low</td>
<td>Optional</td>
<td>1</td>
</tr>
</tbody>
</table>


Low risk cases may be closed. Very high or high risk cases cannot be closed until a later reassessment demonstrates that the risk is lowered. Moderate risk cases should remain open, but may be closed with a manager’s approval because of resource constraints. Risk is reassessed at three-monthly intervals and immediately before closure.50

DEFICITS IN ASSESSMENT
The Commission observed Families SA assessments of numerous cases, including individual child case studies (see Vol. 2, Case Studies 1 to 4). The Commission reviewed 19 specific cases in its Cumulative Harm review and 60 C3MS case files in its Usual Practice review (see Appendix C). Some of these assessments were reported to the Commission as being concerning and warranting review. This potential bias was offset by the Usual Practice review, which randomly sampled cases notified to Families SA in 2013/14. Among all the cases assessed, the Commission observed some common themes on the part of Families SA practitioners, including:

• excessive optimism;
• concerns viewed in isolation;
• cursory investigations;
9 INTERVENTION WHERE THERE IS IMMINENT RISK

- a lack of focus on the child;
- too little reliance on the expertise of other practitioners;
- too much reliance on the decision-making tools;
- inappropriate referrals; and
- unrealistic safety plans.

These issues are discussed below.

EXCESSIVE OPTIMISM

Many assessments were plagued by naive optimism about the potential for extremely disadvantaged and poorly functioning families to change. There was repeated evidence of practitioners failing to understand the difficulty for people to overcome addiction and substance abuse problems, violent behaviour and serious mental health conditions. Children often suffered the consequences of misguided efforts, and were left in unsafe situations where they sustained further harm.

The files demonstrated a clear preference for family maintenance and reunification: keeping families together at all costs. There was little evidence that practitioners understood the damaging effects of trauma on child development.

Similar observations have been made in recent South Australian coronial inquiries. The inquest into the death of Chloe Valentine found that Families SA practitioners made unrealistic positive assessments of the mother’s insight into Chloe’s needs, despite longstanding child protection concerns and serious incidents of neglectful parenting. The Coroner noted they were ‘blindly searching for something optimistic in this family picture, as if to reinforce their perceived success at intervention’.53

The inquest into the death of Ebony Simone Napier criticised the failure to remove Ebony from her parents’ care before her death. Families SA’s closure note reported an investigation had ‘cleared’ her parents of causing her leg fracture when, at best, her father’s explanation was a possibility only and an ‘intrinsically unlikely’ one.54 The record exaggerated the parents’ engagement with a support service in spite of their tendency not to engage except when it suited them.55

The Coroner also observed a tendency to downplay the dangers of marijuana consumption, in the face of evidence that the father was aggressive and violent after smoking marijuana.54

CONCERNS VIEWED IN ISOLATION

Families SA appeared to view interventions in isolation. Notifications were treated as discrete events, rather than opportunities to build a more complete picture of the child’s situation. This meant information was lost over time, rather than accumulating from one report to the next. Practitioners seemed to assume that past problems had been resolved at case closure and did not take the opportunity to review the rationale for decisions on previous notifications, such as those coded Notifier Only Concern or Closed, Abuse Not Substantiated.

Child neglect and abuse were viewed as episodic, rather than as part of a pattern, with serious consequences for the child’s development and wellbeing. Risk factors such as poor care were not viewed as serious enough to warrant assertive intervention. Evidence of past incapacity to parent, including the removal of other children, was largely ignored.

As discussed in Chapter 7, the Families SA Call Centre decision-making tools encouraged an isolated view by not assigning weight to patterns of harmful behaviour or the effects of cumulative harm. Families SA accepts the need to review these tools to respond better to cumulative harm and neglect.56

CURSORY INVESTIGATIONS

Families SA investigations often appeared cursory and incomplete. It was common to see a report of a home visit in which parents’ responses to questions were accepted uncritically, only to be followed immediately by further notifications. It was rare to see the integration of material from other relevant sources and the development of a comprehensive picture of the child and his or her needs.

Assessment of children generally appeared simplistic and incomplete, with little or no recognition of the psychological, developmental and behavioural impact of traumatic, unsafe and chaotic environments. Families SA did not request timely, comprehensive developmental assessments of a child in any of the 19 cases examined in the Cumulative Harm review. This suggests a failure to understand fully the negative effect of abuse and neglect and its cumulative damage on children and the longer-term effect on their development. The lack of focus on child wellbeing was concerning, especially where family members, neighbours and professionals continued to identify cumulative harm and a lack of safety.

LACK OF FOCUS ON THE CHILD

An essential part of the assessment process should be listening to what the child has to say. If the child is too young to speak, the assessment should include speaking to a number of adults who can reliably describe the child’s experience. When children can speak, they should be supported to do so and their views heard and given appropriate weight.

Children in care who participated in the Commission’s consultation said they want to be treated with respect and have their opinions valued. They want to be able to participate meaningfully in decisions about their lives.
TOO MUCH RELIANCE ON DECISION-MAKING TOOLS
The decision-making tools used by practitioners in Families SA are not a replacement for knowledge and understanding. The tools contain questions based on actuarial measures that guide risk and safety assessments and help determine Families SA’s response. The tools often produce completely different ratings based on the same information, depending on the Families SA practitioner. Practitioners can apply an optimistic or pessimistic spin on information to produce the rating that they want. Therefore the tools must be supplemented by sound theoretical knowledge and depth of experience.

However, in the cases reviewed in the Usual Practice review, the use of tools did not appear to support the exercise of professional judgment. There was no evidence of critical commentaries on the parameters within the tools, nor on the final rating produced by the tools. The tools often appeared to be applied inconsistently and mechanistically. It was not uncommon to see incompatible responses on decision-making tool forms, which made the final rating almost nonsensical. It was common to see negative responses to many questions on these forms in the face of obvious evidence of high-risk circumstances.

INAPPROPRIATE REFERRALS
In many cases, Families SA practitioners appeared to refer families to support services in an inappropriate manner. There was no discussion with the agency as to the services that it could provide or whether rehabilitation was likely. Nor was there any follow-up with the agency to confirm that parents had kept appointments or achieved their therapeutic goals. Cases were simply referred, and closed, often without consultation with the notifier who had made the initial report. In numerous cases, the Commission observed referrals that did not address the risk to children, who went on to suffer further harm.

UNREALISTIC SAFETY PLANS
As discussed, safety plans have been used to prematurely close cases. The plans also have lost focus: no longer directed to short-term measures to secure immediate safety, they have become case-planning documents that address longer-term concerns with parents. As a result, it is often unclear when a safety plan has been breached and what consequences should follow. For example, in the Chloe Valentine inquest, the South Australian Coroner criticised the repeated use of safety plans despite the mother breaching earlier, similar agreements without apparent consequence.
9 INTERVENTION WHERE THERE IS IMMINENT RISK

Child safety should not be entrusted solely to people in the child’s life who have been unable to secure safety in the past. Good safety plans require monitoring by trustworthy third parties, such as a friend or family member, to ensure safety is maintained. The plans should address not only the symptoms, but also the behavioural causes, of past maltreatment. For example, a safety plan for an alcoholic father who hits his children when he is drunk cannot simply rely on his commitment not to drink. It should include the specific steps that he needs to take and external monitoring to ensure that the plan is honoured and the children are safe.64

The Commission reviewed many safety plans in the course of its enquiries and found that many embraced unacceptable levels of risk to children. They betrayed excessive optimism about the capacity of parents, many of whom were clearly leading chaotic, violent and neglectful lives. Safety plans were frequently breached, only for Families SA to initiate a further plan without regard to the litany of previous failures. For example, one plan simply required a mother with a long-term alcohol problem to stop drinking and another left the safe management of a new baby with two very young and struggling care-leaver parents, without involving a specialised support service.

A witness described recent safety plans that appeared to be used as a substitute for more formal intervention, with files promptly closed after the plan was signed. The circumstances of these plans were as follows65:

- A two-year-old girl was brought to hospital, unable to walk, having ingested methamphetamine after she was left in a room while her father and others smoked drugs. The child had been born with traces of methamphetamine in her body and there had been six previous child protection notifications related to her parents’ drug abuse and trafficking. The mother was pregnant again and still using methamphetamines. The response was a further safety plan, despite the parents taking no responsibility for the situation.
- A 14-year-old girl alleged her brother and his friends had sexually assaulted her for a number of years, including tying her up, and that her mother did not protect her. The safety plan described the problem in terms of the child’s ‘sexual health’.

CONCLUSIONS CONCERNING ASSESSMENTS

The Commission expected to find examples of poor assessments: this is a function of high-risk, high-volume decision making. However, it was surprising and disturbing to find that the general standard of assessment in the cases reviewed was poor.

It is tempting to respond to poor decision making by recommending additional prescriptive requirements for child protection practitioners. Child protection reviews have a tendency to blame tragic incidents on human error and recommend new ways to control professionals so they do not make mistakes. Common measures include increased psychological pressure to try harder, reduced scope for individual judgement by adding procedures and rules, and increased monitoring to ensure compliance with the procedures and rules:

Each addition in isolation makes sense, but the cumulative effect is to create a work environment full of obstacles to keeping a clear focus on meeting the needs of children.66

Child protection involves complex problems that call for practice wisdom and professional judgement. Rather than prescription, the focus should be on investing in the professional workforce through rich professional training and clinical supervision, and fostering a culture that promotes ongoing learning and critical reflection.67 These themes are discussed further in Chapters 5 and 6.

The nature of the assessment process may vary depending on the type of the concerns being investigated. However, the response should generally include the following minimum elements: a face-to-face assessment of the child and the family’s circumstances, including a discussion with the parents, an opportunity to sight the child and, if the child can speak, to allow the child to describe his or her experience; an independent perspective on the family’s and child’s wellbeing, for example, from the child’s doctor, school or childcare centre, or from a family, friend or neighbour; the notifier should also be consulted to ascertain whether they can shed further light on the situation.

In the short-to-medium term, the focus of practitioner training and supervision should be on addressing the key deficits in assessment identified above. To achieve this, Families SA should:

- acknowledge that its thresholds of risk and safety are too high and invest in training and clinical supervision to recalibrate assessments over time;
- view the life of a child as a continuum, rather than as a series of isolated incidents. Practitioners should reconsider past allegations in light of fresh concerns and consider whether the combination of incidents indicates an ongoing risk of cumulative harm;
- have the appetite to pursue a thorough assessment when it is required. Practitioners should acknowledge that the complexity of issues facing many families demands a thorough assessment, in particular to determine the cumulative effect of these issues on children. In those cases, evidence should be sought from a variety of sources and integrated to give an holistic picture;
• place greater emphasis on hearing, understanding and valuing the opinions of children. The Agency should invest in a tool, such as Three Houses, to help practitioners learn how best to listen to and talk with children;
• respect the knowledge and experience of child protection experts outside Families SA, and allow their views and concerns to play a greater part in the assessment process and planning interventions. Referrals to support services should occur in the context of a genuine, therapeutic partnership, with the Agency keeping its file open until it is satisfied that the therapeutic goals are being achieved;
• review the decision-making assessment tools to give sufficient weight to issues such as neglect, cumulative harm and social isolation, and train and supervise practitioners in how to respond proactively in these areas. Practitioners should be encouraged to depart from the tools where professional judgement suggests this is required; and
• avoid using safety plans as a substitute for more formal intervention. Safety plans have a defined, but limited, role in child protection practice. Practitioners should be realistic about the parents’ capacity to change, and include effective monitoring in safety plans.

COMMUNITY RESPONSES FOR TIER 3 CASES

Tier 3 intakes receive a ‘community response’. Until late June 2015, this meant practitioners were supposed to invite the parents by letter to attend a family meeting to discuss the concerns, usually at the Families SA office. The letter stated that concerns raised would not be investigated. Families SA did not generally visit the home or sight the child.68

Table 9.5 shows the proportion of Tier 3 intakes where families were invited to a meeting and the proportion of invitations which resulted in families attending the meeting.

Few Tier 3 intakes resulted in an invitation and, in the past three financial years, less than half of the invitations resulted in a meeting. The number of invitations and meetings has steadily declined during the past four financial years, with only 33 meetings held in 2014/15.

Table 9.5: Proportion of Tier 3 intakes invited to Family Care Meetings and attendance rates, 2011/12 to 2014/15

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 3 intakes</td>
<td>2316</td>
<td>1902</td>
<td>1466</td>
<td>1312</td>
</tr>
<tr>
<td>Family Care Meeting invitations to Tier 3 intakes (% of total)</td>
<td>279 (12%)</td>
<td>228 (12%)</td>
<td>182 (12%)</td>
<td>78 (6%)</td>
</tr>
<tr>
<td>Family Care Meetings attended by Tier 3 intakes (% of total)</td>
<td>141 (51%)</td>
<td>95 (42%)</td>
<td>60 (33%)</td>
<td>33 (42%)</td>
</tr>
</tbody>
</table>

Source: Data provided by Families SA.
It is impossible to determine what response the letter would have received in James’s household, but merely sending the letter may have heightened the risk to James by increasing his social isolation. It would have confirmed his mother’s fears: she had allowed a service into her home and Families SA became involved as a result. In this case, the sending of a letter without any accompanying investigative or support response illustrates the danger of partial involvement possibly increasing the risk to the child.

In June 2015, Families SA introduced Linking Families (LF), which responds to all Tier 3 and some lower-risk Tier 2 intakes, and some Adolescent at Risk and Report on Unborn notifications. This phone-based service aims to refer families to relevant support services. As discussed in Chapter 8, there are several problems with LF.

Among these is the fact that some more serious Tier 3 cases require an investigative response from Families SA, rather than a service referral. This response may vary depending on the concerns being investigated, but should include the minimum elements listed above for Tier 1 and 2 cases.

WHERE THERE IS NO RESPONSE

As Table 9.2 shows, in 2014/15 less than 30 per cent of screened-in notifications attracted an investigative response. In some cases, an investigation is not appropriate. However, this decision should be determined by what will keep the child safe from harm, not what resources are available.

CLOSED NO ACTION

The code Closed No Action (CNA) identifies a case that has been closed with no action being taken, because there are ‘insufficient resources to conduct the required investigation or family meeting ... after having weighed the relative case risk against other incoming child protection work’. CNA is applied only to Tier 2 and Tier 3 intakes.

CNA is used in a similar way to a code used by Families SA in the late 1990s, called Resources Prevent Investigation (RPI). When RPIs rose dramatically to 1014 cases in 1999–2000, the state government provided Families SA with additional funding to abolish its use. CNA has effectively replaced RPI—and on a much larger scale. Table 9.6 sets out the amount of CNA use during the past four financial years.

The use of the code rose to 61 per cent in 2014/15. The percentage is not uniform across the state. For example, the Northern Assessment and Support Hub at Elizabeth received 948 screened-in notifications in 2014/15 and coded 84 per cent as CNA. Families SA policy forbids the closure of Tier 1 intakes for resource reasons. However, as shown in Table 9.7 and Figure 9.1, the CNA code is widely used in relation to Tier 2 and 3 intakes. In 2014/15, 63 per cent of Tier 2 intakes and 83 per cent of Tier 3 intakes were Closed No Action.

The Commission was told that allocation meetings at Families SA’s Central Assessment and Support Hub do not even consider responding to Tier 3 intakes; they are simply coded CNA.

<table>
<thead>
<tr>
<th>Tier 2 intakes coded CNA (% of total)</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>13,587</td>
<td>13,539</td>
<td>14,310</td>
<td>16,787</td>
<td></td>
</tr>
<tr>
<td>6764</td>
<td>7198</td>
<td>6935</td>
<td>10,568</td>
<td></td>
</tr>
<tr>
<td>(50%)</td>
<td>(53%)</td>
<td>(48%)</td>
<td>(63%)</td>
<td></td>
</tr>
<tr>
<td>Tier 3 intakes coded CNA (% of total)</td>
<td>2316</td>
<td>1902</td>
<td>1466</td>
<td>1312</td>
</tr>
<tr>
<td>1476</td>
<td>1262</td>
<td>984</td>
<td>1090</td>
<td></td>
</tr>
<tr>
<td>(64%)</td>
<td>(66%)</td>
<td>(67%)</td>
<td>(83%)</td>
<td></td>
</tr>
</tbody>
</table>

Note: Excludes extra-familial notifications, which are referred to SA Police.

Source: Data provided by Families SA.
A child who is the subject of a notification that is coded CNA receives no service. In most circumstances, neither the child nor the child’s family will even be aware that a notification has been made. It is curious that Families SA considers any inaction in relation to a notification of abuse and neglect to be acceptable. Once a concern has been screened-in, the agency has accepted that the information reveals a genuine child protection issue that requires a response. Any inaction on the basis of an overwhelming workload is patently unacceptable, and leaves many children living in risky and unsafe conditions.

To ignore a genuine child protection issue because of an overwhelming workload is unacceptable, and leaves many children living in risky and unsafe conditions.

The response priority tool is not designed to screen notifications to determine whether a response is or is not required. Rather, it is designed to assist an agency to prioritise responses. Determining how quickly a response should be provided is an entirely different matter to determining whether a service will be provided at all.

It is important to recall that Families SA Call Centre practitioners inevitably base their response priority on an incomplete picture of the child and their circumstances. There are usually significant other sources of information not available to the Call Centre, such as the child’s neighbours, extended family members, teachers or health practitioners. This information will not be captured at the point of intake, which relies only on the information from the notifier, supplemented by historical data that may be available on C3MS. To base a decision effectively to deny a response to a child with a screened-in notification on an incomplete picture is dangerous for the child.

It is no comfort that the CNA code is limited to Tier 2 and 3 cases. As noted in this chapter, the Commission has seen numerous examples of Tier 3 intakes that call for prompt assessments to determine the safety of the children involved.

Under Families SA policy, if three or more consecutive screened-in notifications in relation to a child are coded CNA, the next screened-in notification should be actioned unless a Director approves it being coded CNA. Such approvals do not appear to be unusual: one witness reported having asked a Director to approve an eighth consecutive CNA in relation to one child. Further, the policy is easily avoided. Screened-in notifications are not consecutive if there is an intervening screened-out notification. For example, if three consecutive Tier 2 intakes are coded CNA and the next is a Notifier Only Concern (because it does not reach the threshold to be screened in), a following Tier 2 intake can be coded CNA without approval. Similarly, if Families SA codes three consecutive Tier 2 intakes as CNA, and then provides some intervention to a fourth Tier 2 intake before closing the file, a fifth Tier 2 intake could be coded CNA without the approval of a director.

Figure 9.1: Percentage of intakes coded Closed No Action, 2011/12 to 2014/15

Source: Data provided by Families SA.
This is despite clear evidence that repeat notifications are a significant risk factor associated with problem behaviours, problems with peers, substance abuse, depression and anxiety, lower intelligence, poor sense of safety and stability, and reduced wellbeing.\textsuperscript{81}

It is startling—and suggests acquiescence in the face of overwhelming demand—that Families SA policy would even contemplate the use of CNA in relation to four or more consecutive notifications.

OTHER CLOSURE CODES
As well as CNA, Families SA uses a range of other closure codes to justify making no response or a minimal response. They are \textsuperscript{82}:

- Full Investigation Not Required (FNR)—Families SA contacts the notifier before speaking to the family and the notifier provides further information indicating an investigation is not needed.
- Refer Other Agency (ROA)—An agency working with the family agrees that an investigation is not required.
- No Grounds for Intervention (NGI)—Families SA has no role as the matter is being adequately responded to by others.
- Closed Not Located (CNL)—The family cannot be located, despite reasonable effort.
- Could Not Complete Investigation (CNCI)—Families SA initiates an investigation, but due to unexpected higher priority work, the investigation cannot be completed. Or, the investigation is stymied when the family refuses to respond.

There is reason to believe that Families SA’s decision to use at least some of these codes is also based on resources, particularly CNCI. Further, the Commission heard evidence that workload generally forms part of the decision to use the FNR code, a code used even for Tier 1 intakes.\textsuperscript{83}

In the case of James (see Volume 2, Case Study 1), a Tier 2 intake received by Families SA soon after his birth was closed using the code FNR, on the basis that service referrals would be made by the Women’s and Children’s Hospital social work department. The use of the FNR code meant that the file was closed without any follow-up or monitoring of the service response. James’s mother did not engage meaningfully with any of the services and there was no reduction in his level of risk.

The current use of CNA and other closure codes sends a message to children, parents, notifiers and the broader community that some concerns are not worthy of response and, by extension, that some children are not worthy of protection.\textsuperscript{19}

The current use of closure codes sends a message to children, parents, notifiers and the broader community that some concerns are not worthy of response and, by extension, that some children are not worthy of protection.\textsuperscript{99}

The Agency should be resourced to respond to all screened-in notifications, either directly or, for low-level notifications, by referral to appropriate government and not-for-profit support agencies. This reflects the community’s commitment to listen and respond to all children who are reasonably suspected of being at risk.

It is plain that the Agency’s resources do not permit anything approaching this ideal. Indeed, there is reason to doubt whether the trained workforce currently available for recruitment is large enough to meet the task (see Chapter 6). The yawning gap between the commitment to respond to at-risk children and Families SA’s resources has grown wider over successive years and will take time to close.

In this context, some decisions not to respond to at-risk children on the basis of resources, while unacceptable, is inevitable in the short term. Codes for the closure of files due to resources should be consolidated and practitioners given clear guidelines as to the circumstances of their use. The use of these closure codes should be tracked in accordance with consistent guidelines and the results made public at least quarterly, to allow the community to understand the limits of the Agency’s capacity. The Agency should tell notifiers if it intends to use these closure codes on specific cases, to enable notifiers to take any other measures to care for and protect the child.

While the Agency should reduce the use of closure codes due to resources, it should resist measures that manipulate the rate of response without improving the health, safety and wellbeing of children. It can be tempting to deliver some services, thus avoiding the coding of a notification as a CNA, even though the nature of the service does not address the risk to the child. The Commission considers that this is all the Linking Families service does in many cases. The aim should be to improve safety, not statistics.
The Agency should aim to abolish the use of closure codes associated with resource demand within five years. To achieve this, it should project the level of demand and, together with Treasury, assess the resources required to meet this demand. This will be an inexact process to begin with as the system has been desperately under-resourced for a long period. Over time, providing improved, timely responses to vulnerable and at-risk families will moderate demand on the system. It is likely that regular reviews will be needed over successive years to ensure that resources continue to meet the task of responding assertively to at-risk children.

A MANDATORY RESPONSE?

Section 19(1) of the Children’s Protection Act provides that where the Chief Executive ‘suspects on reasonable grounds that a child is at risk’ and ‘believes that the matters causing the child to be at risk are not being adequately addressed’, he or she:

Must cause an assessment of, or investigation into, the circumstances of the child to be carried out or must effect an alternative response which more appropriately addresses the potential or actual risk to the child. [Emphasis added.]

The options of ‘assessment’, ‘investigation’ or ‘alternative response’ mean the response may vary: a forensic investigation, a broader assessment, an alternative response from a support agency, or some combination of the three. Whatever form the response takes, the Act clearly envisages purposeful engagement to address the risk to the child. Understood in this light, section 19(1) sits uncomfortably alongside the current, widespread use of the CNA code.

Screened-in notifications are assessed by the Families SA Call Centre as meeting the definitions for abuse or neglect, and therefore they constitute suspicion ‘on reasonable grounds that a child is at risk’. Section 19(1) also requires a positive belief ‘that the matters causing the child to be at risk are not being adequately addressed’. This substantially reduces the provision’s operation, because, without some investigation, it may not be known whether the matters are being addressed. However, in cases where the same concerns are re-notified over an extended period, it should be obvious that the concerns are not being adequately addressed. In those cases, the state of mind in section 19(1) plainly exists and the Agency should respond. Using CNA in these cases is not only dangerous, but also arguably unlawful.

Yet it should not take multiple notifications before an assertive response occurs, because in the meantime, concerns escalate and become entrenched and children experience prolonged trauma. Consistent with the aim to respond early to suspected abuse and neglect, section 19(1) should be amended to read:

(1) If the Chief Executive suspects on reasonable grounds that a child is at risk, the Chief Executive must cause an assessment of, or investigation into, the circumstances of the child to be carried out or must effect an alternative response which more appropriately addresses the potential or actual risk to the child.

The Act would continue to excuse the Agency from responding where proper arrangements exist for the care and protection of the child and the apparent abuse or neglect has been or is being adequately dealt with. However, ignorance of whether the risk is being addressed would no longer excuse a failure to respond.

The amendment reflects the community’s commitment, described above, to respond to all children who are suspected of being at risk. While the nature of that response may vary depending on the circumstances of the case, it would require an assertive response to address the risk to the child.

Consistent with the aim to initially reduce, and ultimately abolish, the use of closure codes because of resourcing issues, section 19(1) should be amended as above within five years, or earlier if resources permit.

REQUIREMENT TO SEEK ORDERS IN RELATION TO DRUG ABUSE

Section 20(2) of the Act provides that if Families SA is of the opinion that a child is at risk as a result of the abuse of a drug (including alcohol) by a parent, guardian or other person, it must apply for an order directing the person to undergo a drug assessment. An exception applies where a drug assessment of an appropriate kind has already occurred, or is occurring, and the results have been, or will be, made available to Families SA.

Section 20(2) was amended recently in response to recommendations made in the Chloe Valentine inquest. The Coroner strongly criticised Families SA for not seeking an order requiring the mother to undergo a drug assessment. He found that there was at least one occasion, and probably several, when Families SA workers must have suspected on reasonable grounds that the child was at risk due to drug abuse. This criticism was well-founded.
Drug abuse rarely occurs in isolation, but in combination with other concerns, such as mental health, domestic violence, physical abuse and neglect. Nor does the court see applications for an order for drug assessment in isolation. Rather, this order is sought in conjunction with other assessment orders and invariably an application for custody.87

The abuse of drugs poses significant risks to children. The Commission observed numerous cases where practitioners made unrealistic assessments of parents with substantial drug abuse problems, leaving children in unsafe situations where they sustained further harm. Yet this reflects the broader issue discussed above that Families SA’s thresholds of risk and safety are too high and require recalibration. This approach places children at risk, not only because of drug use, but also because of other issues, including family violence, mental illness, physical abuse and neglect.

The amended section 20(2) selects drug abuse for special treatment, when what is needed is an assertive response to protect children from all types of abuse and neglect. In some cases, the response will require an application for court orders, for example, for drug assessment. In those cases, the Agency should not hesitate. However, it is unrealistic to prescribe by legislation when such an application should occur. This is a matter for professional judgment by trained, experienced practitioners under ongoing clinical supervision and supported by clear organisational policy as to the importance of responding to protect children from all types of abuse and neglect. A legislative mandate would mean that workload management efforts would focus on the need to comply with legislation to address particular kinds of risk, potentially neglecting other, equally serious, types of risk.

As this chapter observes concerning orders to access information, when Families SA seeks a court order requiring parents to undergo a drug or alcohol assessment, the application is invariably uncontested. This burdens the court with applications that are not opposed and has the potential to drive the parties into an unnecessary adversarial process.

Section 20(2) should be repealed. In its absence, section 20(1) would permit but not compel the Agency to commence proceedings to seek an order requiring a drug or alcohol assessment in appropriate cases.

Futher, the Act should be amended to empower the Agency, if it suspects a child is at risk as a result of the abuse of drugs or alcohol by a parent, guardian or other person, to issue a written direction requiring them to submit to an assessment, with the results to be provided to the Agency. The direction would be binding unless the parent disputes the grounds on which the direction is made, in which case the matter would be referred to the court for consideration. Failure to comply with a valid direction would be relevant to decision making under the Act (including in subsequent court proceedings), for example, when assessing a parent’s capacity or willingness to make the changes necessary to safely care for the child. Failure to comply would not give rise to any other civil or criminal liability.

ROLE FOR SPECIALIST ASSESSMENT

In complex cases, the assessment process is aided by independent, expert assessments. Psychologists perform a range of assessments to examine a child’s development, intelligence, and emotional and behavioural functions, as well as the quality of the parent-child relationship and the effect of trauma in the child. Psychiatrists diagnose mental illness or disorder in children or their parents. With additional training, supervision and mentoring, social workers can also undertake parenting capacity assessments.88

Families SA’s Psychological Services unit performs much of this assessment. It also maintains a panel of private psychologists and psychiatrists experienced in child protection, whom it engages to perform assessment work.89

The Child Protection Services (CPS) units at Flinders Medical Centre (FMC) and the Women’s and Children’s Hospital (WCH) perform forensic medical assessments and forensic interviews of children. The units also employ social workers and psychologists to perform parenting assessments.90 The assessments are labour intensive and take about six weeks to complete. The units have limited capacity and refuse many referrals each year.91 In some cases, the assessment never happens and Families SA intervenes without properly identifying the problem.92

This is a particular issue in the northern suburbs. The Lyell McEwin Hospital (LMH) is South Australia’s second-largest birthing hospital, and is located in an area with a very high proportion of families from low socioeconomic backgrounds.93 Yet it does not have a specialist CPS unit. Although it receives support from the other CPS units, LMH lacks permanent medical staff with specific expertise in child protection, who can provide leadership and consistency in this difficult area of practice. Further, children who require forensic medical assessments, forensic interviewing and parenting assessments must travel to either WCH or FMC.94

The government should establish a CPS unit at LMH to service the high assessment and therapy needs in the northern suburbs of Adelaide.
Families SA’s Redesign process proposed to bolster assessment capacity by training social workers to undertake a range of assessments, with only the most complex cases referred to Families SA psychologists. Critically, the proposal did not address how this model would ensure independence and objectivity. It is unrealistic to expect Families SA caseworkers, who have ongoing relationships with parents and children, to provide entirely independent, expert assessments.

Even in Families SA’s Psychological Services unit, psychologists experience subtle pressure to affiliate with Families SA and to adopt its mindset. The Senior Judge of the Youth Court said experts in the court sometimes appear ‘a little partisan’, presenting reports that resemble ‘a final argument by an advocate’. He said they should be ‘more balanced’ and better grasp their role as independent experts. The judge said this applies not only to experts employed by Families SA, but also to those who depend on referrals from the agency.

As discussed below, many expert witnesses who appear in the Youth Court express concern that the court does not readily accept their evidence. The perception of partisanship described by the Senior Judge no doubt contributes to this.

The Commission recommends that the Act be amended to provide an independent model of expert assessment, similar to the Children’s Court Clinic (CCC) in New South Wales, where the Children’s Court may make an ‘assessment order’ for the assessment or physical, psychological, psychiatric or other medical examination of a child. The CCC may also appoint a person to assess the capacity of a person with, or seeking, parental responsibility (with the consent of that person). In either case, the court must appoint the CCC to prepare the assessment, unless the CCC is unable to do so or views it as more appropriate for another person to do it. The report prepared by the CCC is regarded as a report to the court, rather than as evidence tendered by a party.

The CCC is part of the Sydney Children’s Hospitals Network, NSW Department of Health. It employs a core team of expert clinicians who conduct assessments. It also engages a panel of accredited private psychiatrists, psychologists and social workers across NSW, known as authorised clinicians, to conduct assessments. Importantly, authorised clinicians must advise of any actual or potential conflict of interest that might impair their objectivity in making assessments. Being an employee of the statutory child protection agency is stated to be a ‘clear conflict of interest’.

In South Australia, the two existing hospital-based CPS units offer high-quality, independent assessment services. Together with a new CPS unit at LMH, these units could form the basis for an expanded independent assessment model that is similar to the CCC.

Most of the assessment function of the Families SA Psychological Services unit should be transferred to the hospital-based CPS units, with a portion remaining in Families SA to provide in-house psychological expertise for day-to-day training and practitioner advice, and to offer therapeutic support to children in the care of the state.

Court-ordered assessments would be performed either by CPS or by an approved private assessor from a panel managed by CPS. CPS should establish panels of government, private and not-for-profit organisations that could provide parenting, mental health and drug and alcohol assessments. CPS should also establish procedures and audit the work of these service providers to ensure the delivery of consistent, high-quality, child-focused assessments. This measure would improve confidence in the quality and independence of expert assessments and, in particular, remove the perception that providers might lose work if a recommendation displeases the Agency.

These changes may take some time to implement. In the meantime, the Psychological Services unit should embrace external peer mentoring and supervision, and establish professional links with experienced external psychologists in South Australia to provide this support. This will help address the pressure on staff to conform to a common mindset.

**PROTECTIVE INTERVENTION**

In some cases involving very serious abuse and neglect, an assessment will conclude that parents are incapable of making the changes necessary to provide safe care for the child. In these cases, Families SA seeks to place the child in alternative care according to a long-term order.

Most cases, however, are less clear cut: the assessment process may determine that the child is at risk of harm, but with intervention the parents may be able to address that risk. Protective intervention (PI) describes services provided by Families SA and other agencies that seek to address the issues that cause children to be at risk, to enable them either to remain in their parents’ care or to return there safely.

There are two forms of PI: family preservation services and reunification services. Family preservation services work with families whose children have been removed, seeking to address the concerns so the children can return when it is safe to do so.
REFERRALS TO PROTECTIVE INTERVENTION

As outlined in Chapter 5 Families SA’s Redesign process reorganised metropolitan offices, creating specialist hubs. In this model, practitioners in assessment and support hubs respond to new cases. If the assessment process determines the family should be referred to protective intervention, the Assessment and Support hub transfers the case to a PI hub, subject to criteria.

In reunification cases, where the children have been removed, these criteria include:

- completion of the investigation and case notes;
- completion of all risk, safety, family reunification and family strengths and needs assessments; and
- the existence of a care and protection order for custody or guardianship for up to 12 months, a Voluntary Custody Agreement or a Family Care Meeting Agreement.

In family preservation cases, where the children remain at home, the criteria include:

- an assessment of risk as high or very high;
- an assessment of safety as safe or conditionally safe;
- the existence of an open child protection case with no order, a Family Care Meeting Agreement that includes family preservation services, or a supervision order with a written undertaking;
- that there is no likelihood of the children entering care in the next two to three weeks and a reasonable possibility that intervention will prevent the child entering care; and
- that there is no investigation or assessment order, care and protection custody or guardianship order, or interim court order in existence.

Under the model, PI hubs were to have specialist teams responding to either family preservation or reunification cases. In practice, high demand for reunification services has meant family preservation teams often respond to a mixture of cases.

Regional offices continue to have collocated PI, Assessment and Support, and guardianship teams. In these offices, files are transferred from an assessment and support team to a PI team at the conclusion of the assessment process.

Families SA PI practitioners work in partnership with not-for-profit service providers in the Family Support Services (FSS) program. In 2014/15, FSS cost about $11 million, which was distributed among six providers providing three services: targeted intervention, family preservation and reunification. The current service providers are:

- Centacare Catholic Family Services
- AnglicareSA
- Aboriginal Family Support Services (AFSS)
- ac.care (Anglican Community Care Inc.)
- Centacare Catholic Diocese of Port Pirie
- UnitingCare Wesley Port Pirie.

Families SA also funds some smaller PI providers, such as Connecting Families. In addition, government-run specialist reunification programs, such as the Infant Therapeutic Reunification Service and the Adolescent Late Stage Reunification (ALSR) model (see boxes), target specific age groups.

Regarding ALSR, Families SA supports the concept of late-stage adolescent reunification where children are not in stable placements or abscond to their parents, but historically this support has been limited to situations where the child already has frequent contact and a safe relationship with her or his parents, making safe return possible. By contrast, ALSR proactively builds the capacity of families so they can resume care.

The Commission tentatively endorses the ALSR model as a pragmatic response to a small group of very vulnerable children for whom alternative care is neither safe nor nurturing. The promise of this model should not be overstated. Evidence suggests poor outcomes for older children in care who return to their parents’ care. It will be important to closely monitor outcomes for children involved in the ALSR. Indeed, late-stage reunification arguably represents, in many cases, the system’s failure to offer a child safe, stable out-of-home care that supports his or her development.
The Infant Therapeutic Reunification Service

The Infant Therapeutic Reunification Service (ITRS), which is located at the Women’s and Children’s Hospital, offers a service for children aged less than three years. It typically works with the parent and child together once a week for up to two years. The service also offers individual therapy to parents with their own trauma issues. It is intended that when the ITRS ceases working with a family and the family is reunified, another service will continue working with them in a family preservation context.

The ITRS offers therapeutic assessment to assist the court during care and protection applications, as well as long-term therapy for infants being reunified with parents. Through timely assessment the service aims to provide support before problems become entrenched or disrupt the infant’s development. The ITRS also helps train staff who work for other child protection services in working with infants and supporting successful reunification.

The Adolescent Late Stage Reunification Service

In November 2015, the South Australian Government announced the Adolescent Late Stage Reunification (ALSR) model, committing $4.7 million to the service over four years. ALSR aims to respond to the rising numbers of young people residing in small and large residential care facilities under long-term orders, particularly those who abscond frequently and are reported as missing, by reunifying them with their families.

The ALSR will target 30 families a year with intensive support services for an average of six hours a week during the reunification stage and three hours a week thereafter for up to 12 months. Like other reunification services, ALSR uses Solution Based Casework (SBC) as a framework to formulate case plans. This is to ensure that plans have clearly defined goals to address the challenges facing the family that led to the adolescent’s removal and that are barriers to his or her return. Parents are referred to services that will address their individual needs, such as substance abuse programs, and the young person will be linked to universal services, such as educational, vocational and medical services.1


STRONGER PARTNERSHIP IN PROTECTIVE INTERVENTION

The PI model relies on a strong partnership between Families SA and Family Support Services (FSS) providers. The Families SA PI practitioners assess whether families are ready for reunification or family preservation services and then refer them to the FSS provider. Families SA prepares the intervention goals and retains case management, while the FSS provider provides casework services specific to the family’s needs. Families SA ensures regular communication between the FSS worker, the parents, the parents’ support worker and any other professionals involved, including monthly review meetings to discuss progress in relation to the case plan.114

Families SA PI practitioners are also expected to do direct casework before referring to the FSS provider. They spend time building trust and rapport with families to assess their willingness to work with the FSS provider. They use SBC to work intensively with families to identify challenges, address safety concerns and assess parents’ capacities. Indeed, the hub structure aims to allow PI practitioners to do more direct work with families before referring cases to FSS providers.115

In practice, sometimes it takes months before Families SA refers to an FSS provider. For the child Abby (see Vol. 2, Case Study 2), it was not until six months into the short-term order that her mother was referred to a reunification provider. This requires families to adjust to a new service team at a late stage. In reunification cases, this approach leaves limited time to work with the FSS provider before the first short-term order expires and makes it more likely that a second short-term order will be needed.116

Many families find it difficult to work with Families SA, particularly after it has investigated them or removed their children. The not-for-profit sector is often better placed to build rapport and to work directly with parents.117 Using not-for-profit agencies also means the court potentially has access to assessments independent of the Agency, as discussed above.

The Agency should confine its role in PI work to case management. Before referring to an FSS provider, The Agency needs to assess whether the family appears willing and able to address child protection concerns in a timeframe that is consistent with the child’s needs. This assessment should occur promptly to allow the FSS provider time to engage meaningfully with the family. Moreover, it should be recognised that FSS providers may succeed in engaging families where the Agency cannot and that the primary therapeutic relationship for families should be with the FSS service provider, not the Agency.
**Income management**

Income management is often presented as an option for families in the child protection system. As noted in the inquest into the death of Chloe Valentine, the Commonwealth and South Australia have entered into a bilateral agreement for the implementation of income management. The parties have agreed to use income management as a tool to achieve the following outcomes for the care and protection of children:

- A portion of the individual’s relevant welfare payments is quarantined to meet the priority needs of any dependent child.
- The wellbeing of the child is improved as a result of the intervention.
- The individual’s ability to manage their income for the benefit of themselves and their children is improved.

In March 2016, the federal government started a trial of compulsory income management in Ceduna, in which 80 per cent of welfare payments was quarantined to a cashless debit card that cannot be used for alcohol or gambling. The results of this trial may increase knowledge about the effectiveness of compulsory income management.

There is limited evidence that income management improves financial health or has other positive outcomes for vulnerable children and families. The evidence that exists is poor in quality, meaning the conclusions should be interpreted with caution. There is some evidence that limited improvements in housing and financial stability as a result of income management allow individuals to invest in behavioural change. However, it also appears that sustainable changes may be limited because income management may increase welfare dependency. When income is no longer quarantined, individuals often slip back into old spending habits. Income management is also easy to circumvent.

Of concern, after income management was implemented in the Northern Territory, substantiated cases of child maltreatment increased by 44.5 per cent and the proportion of child neglect cases doubled. Many people on income management reportedly experience shame, embarrassment and stigma.

Income management appears to be more successful when recipients are not compelled but volunteer to take part, and when families engage with additional services and commit to changing their behaviour. The most vulnerable families, with multiple and complex needs and prolonged involvement with the child protection system, are less likely to engage in this manner and do not appear to benefit from income management as much as might be expected.

If income management is implemented, it should form part of a package of services and supports to address the holistic needs of vulnerable children and families. Limited access to services in remote communities may limit positive outcomes. Individual assessments should be conducted before referring welfare recipients to income management to ensure it is suitable for their circumstances and that appropriate additional services can be put in place.

Considering the lack of conclusive evidence that income management has positive outcomes, as well as the practical and emotional hurdles that the program causes individuals, compulsory income management in isolation from other services and support should be avoided.

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2 The Coroner criticised South Australia’s lack of implementation of the Bilateral Agreement and recommended Families SA pursue compulsory income management: _Coroners Court of South Australia, Finding of the Inquest into the death of Valentine, Chloe Lee, Inquest 17 of 2014_, pp. 133-41.


4 Oral evidence: A Elvin; K Brettig; name withheld (W11).
A SHORT DEVELOPMENT WINDOW

It may take parents months or years to address issues sufficiently to safely care for their children. Yet children cannot wait indefinitely:

A ‘child’s time’ in the crucial early years is much shorter than the ‘adult’s time’. A young child cannot wait for the parents to solve their persistent personality problems, childhood traumas, drug abuse and violence. A child cannot be put ‘on hold’.

As outlined in Chapter 3, infants develop an attachment relationship towards their primary caregiver when they are between about six months and four years of age. A secure attachment supports children’s physical, social and emotional development, their ability to form positive relationships, their concept of self and their ability to take risks, accept challenges and cope with failure. Conversely, an insecure attachment during infancy and early childhood makes children susceptible to a host of socio-emotional problems and future academic and psychiatric problems. Abusive or neglectful parents expose their children to ‘highly confusing and contradictory parental behaviours’ that jeopardise the development of a secure attachment relationship.

Children have a small developmental window for parents to address their problems. Leaving children with abusive or neglectful parents, placing them in unstable, temporary alternative care arrangements or moving them back and forth between the two prolongs and compounds their trauma. It places them at heightened risk for attachment disorders and a ‘deep incapacity to trust the adults who want to care for them’.

Purposeful family preservation and reunification services should support parents to quickly make the changes needed to safely care for their children. If parents cannot make these changes in a timeframe consistent with their children’s needs, then the focus should shift to finding stable, long-term alternative carers with whom children can develop a secure attachment to support their development.

COMPLEX PROBLEMS

Families involved in the child protection system typically have multiple, complex problems. By the time a PI response occurs, problems have often become entrenched. Further, children who are exposed to a prolonged period of trauma tend to have more pronounced needs and require more specialised parenting. Addressing multiple, complex issues is difficult work, requiring PI services to respond to families on several fronts.

A study of South Australian children who entered care for the first time between 1 January 2006 and 31 December 2007 found that 88.7 per cent had been exposed to between four and 10 social and family background risk factors. Only 9.7 per cent had between one and three risk factors. Studies of children in Victoria and Tasmania have identified similar patterns.

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PURPOSEFUL FAMILY PRESERVATION

Family preservation is typically a late-stage intervention. Even at this stage, some parents are able to make use of supports to safely care for their children. For other parents, services come too late to address their difficulties in the timeframe their children need.

Evidence suggests parents who are motivated to change tend to do so quickly. A 2010 study examined 57 infants aged less than one year, who were involved in the United Kingdom child protection system. The study followed 43 children to their third birthday. Of the children who remained with their birth parents at age three, 43 per cent were considered to be at continuing risk of significant harm from parents whose situation remained largely unchanged or had deteriorated. The parents of the remaining children had made sufficient changes to be able to offer satisfactory care for the child. Significantly, all but one of these parents who made sufficient changes did so before the child was six months of age.

The study, although small and in another country, does illustrate that ‘early action can be fair to parents as well as in the child’s best interests’. Parents who are motivated to change often experience a defining moment, such as the birth of a baby, the permanent removal of an older child, the death of a close relative from substance abuse, or the realisation they need to disengage from a violent relationship, which helps them to see that they must take substantial action to meet their child’s needs.
In this chapter, the Commission has criticised Families SA’s excessively optimistic assessments about parents’ capacity to change, its preference for keeping families together at all costs, and its acclimatisation to abusive or neglectful family situations. The concerns apply with equal force to family preservation work. These factors cause children to be left in families where they experience ongoing abuse or neglect. The unfocused use of safety plans poses particular dangers for family preservation work, by giving the false impression that concerns are being addressed, while children remain in danger.

Family preservation services should be purposeful, with regular assessments to ensure the situation remains in the children’s best interests. Cases should not be permitted to drift, allowing children to be left in dangerous situations with parents who make no or minimal effort to address the issues that place their children at risk.

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TIME-LIMITED REUNIFICATION

Reunification efforts that continue indefinitely prevent children from forming strong bonds with stable, long-term alternative caregivers. Conversely, if children are returned too early to unsafe family situations, they are at risk of further trauma in their parents’ care and disruption in the event of a return to alternative care.

Reunification services should be purposeful and have a time limit. They should be guided by clear-sighted assessment to determine if the parents have made sufficient changes to allow the children to return home. If the parents do not make these changes in a relatively short timeframe, then reunification efforts should cease and the children should be maintained in a settled and permanent care arrangement.

Families SA policy recognises that timely decision making is particularly important for young children due to the critical periods of development for both the brain and attachment relationships:

Expert opinion is that for younger children in particular, a decision about reunification should not take longer than six to twelve months.¹⁰⁴

Families SA’s evidence-based, reunification assessment tool recommends reunification efforts for infants aged under 12 months should be abandoned after they have been in care for six consecutive months, or nine of the past 12 months. For children over 12 months, reunification should cease after they have been in care for 12 consecutive months, or 15 of the past 24 months.¹⁰⁵

Overriding the tool requires permission from a principal social worker.¹¹¹

Similar timeframes apply in New South Wales¹¹² and Victoria¹¹³, as well as the United Kingdom and United States of America.¹¹⁴

Not only do these timeframes meet children’s need for stability, they also allow for the time it takes most parents who are able to resume the care of their children to do so. As noted, most parents who do make adequate changes, do so quickly.¹³⁵

Children who go home usually do so within the first six months of entering care, with probability decreasing rapidly thereafter.¹⁰⁶ An Australian study tracked, over two years, 1337 children who had entered care in South Australia, Tasmania or Victoria in 2006 or 2007. Of the children who returned home within two years, 57 per cent did so within the first three months, 73 per cent by six months and 89 per cent by 12 months.¹³⁷

In practice, the recommended timeframes are routinely overridden in South Australia. One Families SA practitioner could not recall ever achieving reunification within six months.¹⁰⁸ Reunification efforts tend to be pursued too long, with ordinary cases taking one to two years or longer.¹⁰⁹

The case study of Abby (see Vol. 2, Case Study 2), an Aboriginal girl who was removed from her mother’s care aged two months, is instructive on this topic. A psychological assessment warned that reunification should not be pursued for more than six months because of her attachment needs. The same assessment observed that Abby’s mother faced substantial challenges in making the changes that would be necessary to resume care. Yet Families SA persisted with reunification for more than two years, despite the mother repeatedly failing drug tests and attending access with Abby under the influence of drugs. Families SA also failed to concurrently plan for Abby’s long-term care needs. After she had resided in stable care with non-Aboriginal foster parents for 18 months, Families SA made the decision to move Abby to live with interstate relatives who could support her cultural needs, rather than leave her with foster parents with whom she had developed important attachments. Excessive optimism and the pursuit of reunification at all costs were clearly evident.
Table 9.8 shows how long it takes children in South Australia to be reunified with their parents. Most children who return home do so in the first 12 months. However, in 2013/14 and 2014/15, nearly one-fifth of children took more than two years to return, which implies an extended period of instability.

**RISKS CAUSED BY INAPPROPRIATE REUNIFICATION**

Many children who are reunified with their parents subsequently return to care. This is troubling because children who move in and out of care tend to have ‘the worst overall outcomes’, facing increased risks of developmental trauma and of never finding a safe, stable alternative care placement.140

Table 9.9 shows the number and percentage of South Australian children reunified over the past three financial years who returned to the Minister’s care within six and 18 months.

**Table 9.9: Children reunified and subsequently re-entering care in South Australia, 2012/13 to 2014/15**

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children reunified</td>
<td>139</td>
<td>184</td>
<td>142</td>
</tr>
<tr>
<td>Children returned to care within six months of reunification (% of total)</td>
<td>20 (14%)</td>
<td>38 (21%)</td>
<td>28 (20%)</td>
</tr>
<tr>
<td>Children returned to care within 18 months of reunification (% of total)</td>
<td>33 (24%)</td>
<td>51 (28%)</td>
<td>Not yet available</td>
</tr>
</tbody>
</table>

Note: Relates to children returned to their parents after a period in care according to the Children’s Protection Act, including under a Voluntary Custody Agreement or a custody or guardianship order.

Source: Data provided by Families SA.

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Table 9.9 shows the number and percentage of South Australian children reunified over the past three financial years who returned to the Minister’s care within six and 18 months.

About one-fifth of children reunified in the past two financial years returned to care within six months. Twenty-eight per cent of those who returned to care in 2013/14 did so within 18 months (data for 2014/15 is not yet available). These figures are high even over the relatively short timeframe being examined.
Another measure of reunification success is to consider the proportion of children who are returning to care. Table 9.10 shows these figures for the past three financial years.

Table 9.10: Children re-entering care in South Australia, 2012/13 to 2014/15

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Children Entering Care</th>
<th>Children entering care who had previously entered care (% of total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>877</td>
<td>356 (41%)</td>
</tr>
<tr>
<td>2013/14</td>
<td>761</td>
<td>367 (48%)</td>
</tr>
<tr>
<td>2014/15</td>
<td>960</td>
<td>347 (36%)</td>
</tr>
</tbody>
</table>

Note: Relates to children in the care of the state according to the Children’s Protection Act, including under a Voluntary Custody Agreement or a custody or guardianship order.

Source: Data provided by Families SA.

More than one-third of children entering care in each of the past three financial years were returning to care. In 2013/14, the figure was nearly half. These figures underscore the precarious nature of current reunification practice.

High rates of return to care are not limited to South Australia. A United Kingdom study reviewed 138 neglected children who had returned to their parents at some time in 2001. After two years, 59 per cent had been exposed to further abuse or neglect. After five years, 65 per cent were no longer in their parents’ care. 67 per cent had returned to care at some stage and 72 per cent were subject to a child protection plan.

Another UK study tracked 149 children for an average of four years. The children had been maltreated and spent time in care at some point in 2003/04. Of the 68 children who were reunified, 59 per cent returned to care at least once and one-fifth experienced more than one reunification attempt.

Other British studies variously found that 37 per cent, 40 per cent and 52 per cent of children returned to care after having been reunified. Larger reviews in the USA that were based on agency database records indicate that between 19 per cent and 24 per cent of reunified children return to care within two years.

Nor should the results for children who succeed in returning permanently to their parents’ care be exaggerated. Evidence from the UK and USA suggests these children tend to experience poorer emotional and behavioural outcomes and a heightened risk of further abuse or neglect than those who remain in care.

CONCLUSIONS ABOUT PROTECTIVE INTERVENTION

Family preservation and reunification services work with parents with multiple, entrenched, complex problems. Their children typically have complex behaviours and require particularly attentive care because of their exposure to unsafe circumstances. While some families can meet this challenge consistently and over the long term, it is not surprising that many cannot.

The Agency should review the quality of protective intervention services and assessment in South Australia. Its service accountability division should invest in robust and independent evaluations of the services in which they invest.

PI clearly benefits some children, but it is no panacea and should not be pursued in every case, particularly where parents are unable or unwilling to address their problems. The evidence underscores the need for purposeful, evidence-based interventions, and careful assessment to ensure PI remains in the best interests of individual children and, where children are reunified, that families receive appropriate, ongoing support. This approach to family preservation and reunification services should be aided by the legislative reforms discussed below, which shift the balance towards settled, stable care arrangements that secure children’s health, safety and wellbeing.

Protective intervention clearly benefits some children, but it is no panacea and should not be pursued in every case, particularly where parents are unable or unwilling to address their problems.

FORMAL, VOLUNTARY INTERVENTIONS

Some parents are willing to address their problems, but benefit from a formal structure in which to do it.

SUPERVISION ORDERS

Families SA can apply to the court for a supervision order, which requires parents to undertake, in writing, to do or not to do certain things for up to 12 months. This allows a child to remain with his or her parents, as long as the parents agree to meet basic standards of care or to attend therapy. Under this order, the court may also require the child to be under the supervision of the Chief Executive or some other specified person.
Supervision orders are rarely used. While they require a complete, detailed court application, including the preparation of a court report, referral to the Crown Solicitor’s Office, participation of a children’s representative and attendance at court, they lack any effective review mechanism. The court’s role is complete on making the order. If parents do not comply with undertakings, Families SA may pursue them for contempt of court (a punitive option unlikely to be helpful from a child protection perspective) or commence fresh child protection proceedings. Yet breaching the undertaking may not be a sufficient basis on which to commence fresh proceedings. This leaves many parents effectively unaccountable for their promises and Families SA with ‘a lot of responsibility, but no power to actually enforce it’. It is also peculiar and cumbersome for the court to direct a person to make such promises. While there is benefit in a forum where parents may make formal, specific commitments to address the problems that place their children at risk, directing parents to make such commitments is potentially counterproductive.

Supervision orders should be abandoned in their current form. Section 38(1)(a) of the Act should be repealed. Family Care Meetings (FCMs) are a more appropriate forum for parents to make formal, specific commitments as part of a broader plan to secure the child’s care and protection. FCMs involve participation from relevant agencies involved with the family and offer a more flexible review process to ensure parents, family members and support agencies follow through on their commitments.

**FAMILY CARE MEETINGS**

The Act provides that if Families SA is of the opinion that a child is at risk and arrangements should be made to secure his or her care and protection, a FCM should be convened. Families SA refers the matter to the Conferencing Unit, a division of the Youth Court that employs coordinators to convene FCMs. The coordinator invites attendees and facilitates decision making at the meeting.

The FCM allows the child’s family, together with the coordinator, to make informed decisions about arrangements to secure the child’s care and protection. The following people may attend:

- The child (unless the coordinator views it is not in his or her best interests);
- The child’s parents or guardians;
- Other family members who, in the opinion of the coordinator, should attend;
- A person who has a close association with the child, who should, in the opinion of the coordinator, attend the meeting;
- Support people for the child or the parents or guardians (but not a legal practitioner);
- A Families SA employee;
- If persistent absenteeism from school is involved, a school representative;
- The child’s advocate, if one has been appointed;
- Any person nominated by the coordinator who has examined, assessed, counselled or treated the child in the course of the investigation into the child’s circumstances;
- Any other person nominated by the coordinator for the purpose of providing expert advice or information on matters relevant to the meeting; and
- If the child is an Aboriginal or Torres Strait Islander child, a person nominated by a recognised Aboriginal or Torres Strait Islander organisation.

The FCM generally consists of three parts:

1. **Information exchange**—where Families SA clarifies the child protection concerns. Other professionals involved with the family may present their assessments and recommendations. The child advocate speaks to the meeting about the child’s wishes and views.
2. **Family time**—where the family spends time together (without the other parties) to develop a plan to address the concerns at the meeting. Importantly, the family is asked to respond to the concerns as presented by Families SA and the professionals, rather than to minimise or debate them.
3. **Negotiation**—where the coordinator mediates between Families SA and the family to clarify the final plan and try to reach agreement.

Where possible, decisions are made by consensus. The coordinator records the decisions for signing by the parties, if they agree with the decisions. However, as the Act is construed in practice, decisions are considered valid even if Families SA does not agree, provided the coordinator considers they secure the child’s care and protection.

Many witnesses told the Commission they supported FCMs as a concept. However, there was widespread dissatisfaction that they do not achieve their true potential.

FCMs are based on the family group conference (FGC) model that began in New Zealand in 1989 and exists in one form or another in more than 30 countries and several jurisdictions in Australia. At its heart, FGC lets family members formulate a plan to address the statutory agency’s concerns. When the agency’s concerns are adequately addressed, preference is given to the family’s plan ‘over any other possible plan’.
Research about FGC is promising, but it does not yet demonstrate improved longer-term outcomes for children. Families tend to be satisfied with the process, which usually produces an agreed plan, but only a minority of plans are fully implemented. Models of FGC also vary widely between jurisdictions, making comparison difficult. There is a specific need for research about the use of FCMs in South Australia.

COMPULSORY REFERRALS

Under the Act, an FCM must generally be held before the Minister applies for a care and protection order for the custody or guardianship of a child. This promotes an unhelpful link between FCMs and the commencement of legal proceedings. In 2013/14, the Youth Court Conferencing Unit held 338 FCMs and 36 reviews of FCMs. In about 83 per cent of matters referred to the Conferencing Unit there was already a court order in place. For those matters, Table 9.11 shows the time between the referral and the date on which the order was due to expire, which is commonly when the matter must return to court.

Table 9.11: Average days between referral to the Youth Court Conferencing Unit and expiry of the court order, 2010 to 2014

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days</td>
<td>19</td>
<td>19</td>
<td>27</td>
<td>20</td>
<td>16</td>
</tr>
</tbody>
</table>

Source: Data provided by the Youth Court Conferencing Unit.

The time between the referral and the expiry of the court order rose in 2012, when Families SA directed its staff to refer cases to FCMs earlier. However, the 2013 and 2014 figures show the impetus was not sustained. The result is that Families SA continues to refer matters to FCMs in the shadow of court proceedings. By this stage, Families SA’s relationship with parents has often deteriorated and concerns have escalated to a point where it is difficult for a family plan to avoid the need for court orders.

This limits the scope for productive planning by the family to address the concerns. For FCMs to be effective, they should occur at an earlier time.

The effectively compulsory nature of referrals means many matters referred are unlikely to be assisted by the process. For example, when:

- parents dispute the basis of the child protection concerns or refuse to discuss them;
- Families SA views that the concerns are too serious to avoid a court order; and
- parents have diminished capacity and cannot make informed consent to any ‘agreement’.

Further exceptions could be built into section 27(2) of the Act to excuse calling an FCM in these situations. However, the scope of the necessary exceptions emphasises that a quasi-compulsory scheme is inappropriate. Instead, the Agency should have discretion over whether a matter should be referred for an FCM.

The Layton Review made a similar recommendation, but it was not implemented. Like the Layton Review, the Commission is of the view that section 27(2) should be deleted. Section 27(1) should be amended to reflect the principle that the Agency should consider causing an FCM to be convened when the Minister is of the opinion that a child is at risk and the apparent risk is capable of being addressed by decisions by the child’s family at an FCM. Section 49 should continue to allow the court to refer matters to an FCM where appropriate.

CULTURAL SHIFT

If the Agency is to be entrusted to exercise this discretion appropriately, it should thoroughly embrace the philosophy behind FCMs. Families SA policy acknowledges cultural challenges regarding FCMs:

> Although the safety of the child or young person remains paramount, the emphasis on family decision making requires relinquishment of some of the powers usually held by professionals over planning for the care of children subject to statutory intervention. This requires a willingness to acknowledge the strength families have to determine appropriate care for their children, and to accept a radically different role in supporting family decisions rather than deciding what those decisions ought to be.

However, this cultural shift has not been consistent, with some practitioners approaching FCMs as a formality before litigation, rather than as a collaborative process. The Conferencing Unit reports that practitioners do not want to share decision-making power and rarely engage genuinely in the process. This has possibly been compounded by minimal recent contact between Families SA and the Conferencing Unit, and Families SA’s suspension of FCM training at the start of the Redesign process.

The Agency should approach FCMs collaboratively, and be willing to accept the family’s plan to the exclusion of other plans, where it achieves the safety of the child. This cultural shift requires explicit training, reinforced by supervision and peer support. The relationship between the Conferencing Unit and the Agency should be improved by more frequent contact.
ROLE OF COORDINATOR

An FCM decision cannot be valid unless the Conferencing Unit’s coordinator believes it properly secures the child’s care and protection. There is no corresponding requirement that Families SA must agree with the decision. The Conferencing Unit considers the FCM is successful if the family has a proper opportunity to develop a plan that the coordinator considers secures the child’s care and protection.

However, there is no point in recording an agreement which does not have the support of all the parties. There is no point in parents incorporating support from Families SA or other agencies in their plans if the agencies are not prepared to provide the support. Nor is there utility in deciding the child should remain with parents or other family members without a court order, if Families SA disagrees and proceeds to court. If an agreement is ignored and the parties proceed to court, the FCM ‘could be experienced as disempowering, rather than empowering’.

More fundamentally, the scheme positions the Conferencing Unit’s coordinator as a significant actor, the effective arbiter of the child’s best interests. The coordinator can determine whether the family’s plan addresses Families SA’s concerns, even if Families SA is adamant that it does not. Evidence from both the Conferencing Unit and Families SA showed that coordinators and Families SA workers frequently disagree in this matter.

This places the coordinator in opposition to Families SA, as the statutory agency, and creates a process more akin to arbitration than mediation, upon which FGC is based. Yet there is reason to doubt whether coordinators, in the context of their brief, episodic involvement in FCMs, can safely form a concluded view as to a child’s care and protection, if it contradicts the views of Families SA and other professionals who attend the FCM.

This more active role of the coordinator in this state represents a significant departure from the principles of FGC. In New Zealand, families lead decision making, but the statutory agency must agree with their proposed outcome:

The family is empowered to work with the child protection worker to reach an outcome acceptable to both, or to choose to disagree, with the knowledge that the matter might be referred to the court.

Under FGC guidelines from the USA, family groups ‘lead decision making and agencies agree to support family group plans that address agency concerns’.

The coordinator ‘convenes and guides’ the process, but is not a ‘facilitator’ in the sense of a professional with ‘a more elevated, active and central role in the family meeting’. Rather, the coordinator ‘minimizes his or her own voice and presence in the meeting by bringing forward significant pieces of information as quickly as possible’. If the parties cannot agree, the coordinator asks the family how it would like to proceed, including offering to reconvene at a later date. There is no sense that the coordinator might validate the family’s plan in the face of the agency’s opposition.

FCM coordinators should play a less active role, convening and facilitating meetings and encouraging a collaborative process where the family prepares a plan that satisfies the Agency’s concerns. Section 36(6) of the Act should be amended so that a valid decision requires agreement of the family and the Agency, not the FCM coordinator. Ultimately, if agreement cannot be reached, the court will resolve the matter definitively. However, there should be greater willingness to adjourn FCMs where necessary, rather than to attempt to conclude an agreed plan in a single session. Families may need time to contemplate before finding a solution.

As the Act stands, FCMs include people with a close association with the child, who should, in the opinion of the coordinator, attend the meeting. Foster parents arguably fall within this definition, but are not usually invited. In the case of Abby (see Vol. 2, Case study 2) no one appeared to consider whether the child’s foster parents should have been invited. While it is neither necessary nor appropriate for foster parents to attend every FCM, in some cases they can offer important insight into the child’s circumstances. The policies of the Conferencing Unit and the Agency should be amended to include the need to consider whether in appropriate cases a child’s foster parents should be invited to an FCM.

STATUS OF FCM DECISIONS

As discussed above, research concerning FGC in other jurisdictions suggests that only a minority of plans are fully implemented. There has been no research in South Australia on the implementation of FCM decisions. However, Families SA’s apparent lack of enthusiasm for the process and the fact that decisions may be imposed by the coordinator do not augur well for the implementation of the plans. Even where Families SA does support the decision in writing, it is under no express legal requirement to carry out its terms.

By contrast, legislation in New Zealand requires the statutory agency to give effect to FGC decisions, plans and recommendations, unless they are clearly impracticable or inconsistent with the principles of the legislation.
Some witnesses were content with the current status of FCM decisions, viewing them as a ‘working agreement’. In contrast, the Conferencing Unit told the Commission that FCM decisions should be filed in court and formalised as consent minutes of order.

Promises by family members to do or not to do specific things to address the child protection concerns should be formalised in writing and filed in court. However, such commitments should not have the status of a court order. In light of the entrenched nature of parental problems, it is likely that a proportion of commitments will not be followed, yet it would be unhelpful to prosecute parents for any such failure. Instead, the FCM decision should have the status of a formal commitment known to all the parties and to the court, upon which any of the parties may rely in future proceedings, if appropriate.

As occurs in New Zealand, the Agency should be required by legislation to give effect to FCM decisions (which would be agreed by the parties, not imposed by the coordinator), unless they are impracticable or inconsistent with the principles of the legislation. This would include the Agency providing family members with support, as agreed. If circumstances change, or the plan becomes impractical or inconsistent with the child’s safety and wellbeing, then Families SA should not unilaterally abandon the agreement. Instead, it should reconvene an FCM to review the plan or commence court proceedings.

FCM decisions vary in format and are somewhat vague. If they are to bind the parties, they should be expressed clearly so the parties understand their obligations. Template commitments should be drafted and coordinators should receive specific training regarding their use.

The Conferencing Unit can review FCMs, but this is rare. In 2013/14, it held only 36 reviews. If the parties agree, the plan is being followed and the risks are being addressed, there may be no need for a review. However, as a general rule, FCM decisions should be reviewed after three months, with the parties able to request earlier and/or subsequent reviews, if required. This holds parties to their commitments and allows plans to be refined over time.

PARTICIPATION OF CHILDREN

When the Commission spoke to children in care, one of their key desires was to participate in processes and be heard. They identified that even young children can be asked to ‘write or draw’ their stories or ‘paint or draw a picture on how he/she feels’. Children are invited to FCMs only if the coordinator views it is in their interests. In practice, children do not attend, except as babies, due to the length and structure of the meetings and concern it might cause emotional harm.

The Conferencing Unit would like children to attend more often. However, it states that even though this is rare, FCMs are still ‘focused on the child’s voice’. An advocate attends the FCM to speak on the child’s behalf and in the child’s best interests. Advocates are paid only an honorarium and it is difficult to attract candidates. They are generally community members and do not require minimum qualifications or training.

For a time, a Legal Services Commission (LSC) children’s lawyer based at the Youth Court represented children in all Adelaide-based FCMs. However, the workload became too great and this ceased.

FCMs are a less formal, legal process that, with the exception of the child’s advocate, excludes lawyers. For this reason, the child advocate need not be a lawyer. However, advocates would benefit from training about child development, the effect of abuse and neglect, and how to speak to children. They also need explicit guidelines about how to approach the task, including when to act as a best interests representative as opposed to a direct representative. In the absence of training and guidelines, the quality of representation is likely to vary substantially.

The Conferencing Unit should recruit, train and fund a panel of child advocates who can represent children in FCMs. All child advocates should submit a valid child-related employment screening clearance. If it is not possible to recruit sufficient suitable advocates by paying an honorarium, the Conferencing Unit should be funded to provide adequate remuneration to advocates. The Conferencing Unit should consult with the proposed Children’s Commissioner and the Agency about suitable training for advocates, and prepare guidelines to assist advocates in their task. The guidelines should encourage advocates to meet with children, to help them understand the purposes of the meeting and how the child may be involved. Advocates should work with children to find safe ways for them to participate in the FCM: for example, by attending the meeting or part of it, by writing down or drawing what they want to convey, or by being videotaped offsite for screening at the meeting. The Conferencing Unit should regularly offer performance feedback to child advocates. Poor quality advocates should be removed from the panel.
STATUTORY INTERVENTION

In some cases, the only option to secure children’s safety is to remove them, at least for a time, from their parents’ care.

VOLUNTARY CUSTODY AGREEMENT

A Voluntary Custody Agreement (VCA) is a short-term option. Parents agree to transfer custody of the child to the Minister for up to three months. The parties may extend this for a period up to six months. The parents may revoke the VCA at any time.195

Families SA policy permits VCAs to be used in limited circumstances to resolve conflicts that threaten family breakdown, or to care for children at risk where the parents agree that there is a need for intervention. The relevant issues must be likely to be resolved within three months. VCAs are not used in cases where196:

• the intent is to seek court orders at the expiration of the VCA;
• the issues are longstanding and are unlikely to be resolved within three months;
• the intent is to leave the child in the home under a safety plan;
• the parents do not acknowledge the severity of the problems or their responsibility to address them, or are unable or unwilling to work in partnership with Families SA;
• the parent has a moderate to severe intellectual disability;
• the child has sustained serious inflicted injuries.

ORDERS FOR CUSTODY OR GUARDIANSHIP

Families SA may seek a court order placing the child in the custody of the Minister. In the first place, this usually involves an application for investigation and assessment orders, described above. The court may order that the child be placed in the custody of the Minister for up to six weeks to facilitate the assessment process. If the assessment process has not been completed at the end of six weeks, Families SA can seek a four-week extension.197 Applications for custody are rarely contested and are invariably successful. Between 1 July 2013 and 30 June 2014, the court granted every application for an investigation and assessment custody order.198

If a child is in a situation of serious danger and it is necessary to remove the child to protect him or her from harm, Families SA has the power to do so using necessary force.199 Families SA has until the end of the following working day to determine whether it is safe to return the child to parental care or whether to make an urgent application to the court for a custody order.200 In the 12 months to 24 February 2016, 60 per cent of investigation and assessment order applications were urgent.201

Families SA may also bring care and protection proceedings, seeking custody or guardianship for up to 12 months (a short-term order) or for guardianship until the child turns 18 (a long-term order).202

The number of court applications made by Families SA has recently increased. Table 9.12 compares the number of child protection applications (investigation and assessment, and care and protection) commenced in two 12-month periods.

Investigation and assessment applications rose sharply, while care and protection applications increased by a relatively modest 12.3 per cent. This rise follows the Chloe Valentine inquest, which ran from 14 August 2014 to 9 April 2015. The inquest was heavily publicised and criticised Families SA’s failure to seek court orders.203

Table 9.12: Number of child protection court applications commenced by Families SA

<table>
<thead>
<tr>
<th>NON-URGENT I&amp;A APPLICATIONS</th>
<th>URGENT I&amp;A APPLICATIONS</th>
<th>TOTAL I&amp;A APPLICATIONS</th>
<th>C&amp;P APPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/7/2013 to 30/6/2014</td>
<td>83</td>
<td>125</td>
<td>208</td>
</tr>
<tr>
<td>25/2/2015 to 24/2/2016</td>
<td>149</td>
<td>221</td>
<td>370</td>
</tr>
<tr>
<td>Percentage increase</td>
<td>79.5%</td>
<td>76.8%</td>
<td>77.9%</td>
</tr>
</tbody>
</table>

Note: I&A = investigation and assessment; C&P = care and protection

Source: Data provided by the Crown Solicitor’s Office, Attorney-General’s Department, South Australian Government.
The child’s representative acts on the child’s instructions unless the child is not capable of properly instructing a lawyer. In that case, the lawyer acts ‘according to his or her own view of the best interests of the child.’ It is not uncommon for children to express a wish that may put them in great difficulties. It does not accommodate these children’s desire to participate in the proceedings on their own terms.

The best interests model does not prevent the views of children being communicated to the court, but allows children ‘to express an opinion without feeling responsible for the ultimate decision.’ It need not be inconsistent with the right of children to be heard. However, the role can be confusing for children when their lawyer does not act in accordance with their wishes and for lawyers who have no instructions and are not bound by the wishes or directions of the child. The model also causes many children to feel marginalised. It is a mistake to assume that children are less able to instruct a lawyer than adults: ‘Many children have the maturity and judgment to direct their lawyer, just as many adults have limited maturity and poor judgment but instruct legal representatives.’

A review by the Australian Law Reform Commission (ALRC) in 1997 concluded: Ultimately the needs of children differ to such an extent that there can be no single model appropriate for all children. Children vary greatly in their capabilities, maturity and desire for involvement in litigation concerning themselves and their families. A form of representation suitable for an articulate child at 14 may not be appropriate for a younger or pre-verbal child. The role of a child’s representative should remain fluid.

The model as it operates in practice in South Australia strikes the right balance. It is flexible in that it permits children to participate to the extent that they are able and willing, while allowing their representative to speak on their behalf to the extent that they are not.

The Act would benefit from amendment to clarify this position. The current provision presents representation as a binary role: either direct representation if the child is able and willing to give instructions; or the model presents...
• to indicate the nature of the role to the child, in accordance with the child’s developmental capacity; and
• to indicate to the court on which basis submissions are made.

The ALRC recommends detailed standards for children’s representatives:

The basis of representation and the roles and functions of the representative should be clear to the court, the representative and the child concerned. This requires clear ethical and practical standards for all representatives to ensure that there is appropriate participation of and engagement with the child.221

In 2007, the Law Society of South Australia published Guidelines for Lawyers Acting for Children.222 The guidelines provide that a lawyer must not act as a direct representative and a best interests’ representative in relation to the same child. This is based on New South Wales guidelines, which observe that the direct representative relationship ‘is established under a different set of circumstances and may have encouraged the child to be more open … than with a best interests’ representative’.223

This caution may make sense in jurisdictions with a clear distinction between direct representatives and best interests’ representatives, particularly where lawyers act as a direct representative, for example, in criminal proceedings, and then act for the same child in a best interests’ capacity. However, there is nothing unethical or inappropriate in lawyers acting in the dual role envisaged by the Children’s Protection Act provided that he or she is clear with the child and the court at the outset about the nature of that role. The Law Society of SA recently withdrew the guidelines for revision. The revision should reflect the dual role envisaged by the Act.

At times, the court must consider urgent applications to secure a child’s safety before a lawyer has the opportunity to interview the child. The court’s practice is to appoint a lawyer to act for the child, to make interim orders and then to adjourn until the lawyer can speak to the child.224 Yet no express power authorises this practice. The Act should be amended to permit the court either to appoint a representative in such cases or, in emergencies, to dispense with the need for a representative. In the latter situation, the court should only make interim orders and then adjourn the matter so a properly instructed lawyer can represent the child. These changes were recommended by the Layton Review, but not implemented.225

The Youth Court advised the Commission that the number of hearings requiring the participation of a children’s representative was rising: in 2014/15, they were almost double those in 2013/14. If this trend continues, the state government should seriously consider increasing the resourcing of the child representative service.

DIRECT PARTICIPATION BY CHILDREN

Under the Act, children (whether represented by a legal practitioner or not) must be given a reasonable opportunity to give their views personally to the court about their ongoing care and protection, unless the court is satisfied that the child is not capable of doing so or it would pose a risk to the child’s wellbeing.226 In practice, direct participation only occurs in the small number of cases that proceed to trial. One explanation for this is confusion about the process. The Legal Services Commission advises lawyers:

As [direct participation] is done not in chambers, but in court in front of all parties, it is likely to be daunting to a child, and the child’s separate representative will ask them whether they want to talk to the Court.227

In fact, there is no requirement for children to attend open court and the court’s practice is for children to speak to the judicial officer informally at the bar table, without the other parties. A transcript is prepared and retained in the event of appeal, but not routinely provided to the parties.228

While not all children are able or willing to participate directly, there is too much reluctance about their involvement. Children have a right to be heard in proceedings that concern them.229 Speaking to the judge can convey what is important to them, ‘which may not otherwise be apparent’.230 Research suggests children appreciate their views being sought and involving them directly makes them feel respected, valued and involved.231 When an Australian study interviewed children subject to parenting disputes, 85 per cent said children should be offered the opportunity to talk to the judge in chambers.232

Proceedings can be modified to allow children to communicate their views in a safe environment, including using screens or video evidence, meeting the judge outside the court in a more natural environment, or involving a trusted friend or teacher. In one model, children meet the judicial officer:

in the presence of a family consultant (a child welfare expert), who reports back in open court on what transpired, the child consenting to the meeting at all times and it being explained to the child that anything they say may be recounted to their parents and that confidentiality cannot be guaranteed.233

This role could be performed by the social workers employed at the Youth Court as Family Care Meeting coordinators, discussed above.
Whatever the model, children should have the opportunity to participate in all proceedings, not only cases that proceed to trial. The consent of the adult parties should not prevent children directly participating. Children’s representatives should consider whether children are able to participate and discuss the options with them. The court should satisfy itself that children have had a reasonable opportunity to participate before finalising matters.

**TRAINING FOR LAWYERS**

Child protection is a specialised area of legal work. Lawyers who practice in the area need a sound understanding of areas such as child development, attachment theory, and the developmental consequences of abuse and neglect. It is tempting to view this sort of information as common sense or instinctive. It is a specialist area of knowledge that can be taught, but it does not commonly form part of legal training. Lawyers who act for parents would also benefit from such training because children’s best interests are paramount in child protection proceedings.

The Layton Review recommended that all children’s representatives, except in emergencies, undergo training relevant to their role. The recommendation was not implemented.

South Australian lawyers are already required to complete 10 hours per year of mandatory continuing professional development (CPD) training as a condition of holding a practising certificate. The Commission suggests that child protection lawyers should consider spending at least three hours per year learning about areas relevant to child protection (as part of the existing mandatory CPD requirement). There are many highly skilled practitioners, such as social workers, psychologists, psychiatrists, forensic paediatricians, drug and alcohol workers and other lawyers, who are able to offer this training. The proposed Children’s Commissioner, in consultation with the Legal Services Commission (LSC), the Crown Solicitor’s Office (CSO), the Law Society of South Australia and the Agency, should consider developing a recommended training program.

Most child protection lawyers in South Australia are funded or employed by the LSC or employed by the CSO. These bodies should consider measures to encourage these lawyers to undertake child protection training, for example, by directing employed lawyers to participate in training and, for funded lawyers, by establishing a panel system with mandatory training requirements. The LSC recently established a panel for Independent Children’s Lawyers (ICLs) in the Family Court. Panel lawyers must complete mandatory training, practice primarily in family law, have at least five years’ recent post-admission experience in family law and hold a national police clearance.

Lawyers representing children in state child protection proceedings are not required to submit a child-related employment screening clearance. This is concerning as they frequently meet alone with traumatised children. The LSC should require these lawyers to submit a valid clearance as a condition of funding.

**TRAINING FOR JUDGES**

The Layton Review also made recommendations about training for judges and the topic was a recurring theme in evidence heard by the Commission. It is widely accepted that experience as a barrister alone is insufficient preparation for many aspects of judicial work, with ‘very considerable advantages to be gained from a more structured process of learning’. At the same time, independence of the judiciary must be safeguarded.

There are powerful constitutional and philosophical reasons why Parliament cannot require judicial officers to complete training and why training should continue to be overseen by judges themselves.

The Layton Review recommended that Youth Court magistrates and judges:

> Undergo a specific education program which includes topics such as child development, the signs and symptoms of child neglect and abuse and their impact on children's behaviour, the effect of domestic violence on children and the purpose and effect of access in relation to the needs of children.

This recommendation was not implemented. The Senior Judge said that when he started at the Youth Court he and the other judicial officers would meet with various experts, including psychologists, psychiatrists and people from Families SA to cover issues such as attachment theory. It would appear that these activities were not sustained over time, and in current judicial education programs there is a paucity of material relevant to child protection.

This has perhaps contributed to a perception from many experts and lawyers who appear in the court that the judiciary has an incomplete understanding of issues such as child development, attachment theory, the effect of neglect and cumulative harm, and the effect of exposure to domestic violence or drug taking. Confidence in the judiciary has an incomplete understanding of issues such as child development, attachment theory, the effect of neglect and cumulative harm, and the effect of exposure to domestic violence or drug taking. Confidence in the judiciary would be strengthened if it engaged visibly, consistently and proactively in training of this kind.
PROMOTING STABILITY AND PERMANENCY

There is tension between giving parents time to make necessary changes and making timely decisions to offer children stability and security. More time for parents often comes at the expense of children’s developmental and psychological need for stability. Extended uncertainty is unsettling for children old enough to understand and also for infants, whose foster parents are left ‘emotionally on hold’, inevitably ‘holding back a bit’, not knowing if this child they love will remain with them or be removed. This risks undermining children’s broader development. \(^{242}\)

This tension plays out visibly in the Youth Court which, in relation to custody or guardianship, can make either a short-term order (up to 12 months) or a long-term order (until the child turns 18). In a bid to give parents more time, the court often decides to grant a second or third short-term order rather than a long-term order.

The Layton Review observed that multiple short-term orders ‘on occasions resulted in a lack of certainty in relation to the long-term planning arrangements for children’. \(^{243}\) The review recommended that in most cases short-term orders last for no more than 12 months. However, where ‘it was important for the child and family to have an opportunity to assess the situation before a long-term plan was put in place’, the court should have the power to extend the initial order up to 18 months in total. \(^{244}\) A further period of up to 12 months could be permitted in exceptional circumstances, for example, to allow time for culturally appropriate placements to be made for Aboriginal children. \(^{246}\)

However, instead of the amendments to the Act that were recommended, Parliament inserted sections 38(2) and (2a):

\(2a\) If a child is to be placed in guardianship the Court must consider the importance of settled and stable living arrangements for the child and, as a general rule, a long-term guardianship order (ie an order under subsection (1)(d)) is to be preferred to a series of temporary arrangements for the custody or guardianship of the child.

Section 38(2)(a) is problematic. A child may have had limited contact with his or her biological parents and been cared for and become attached to a foster parent for a significant period as part of a stable and loving foster family. However, if the biological parent reappears and presents as willing, capable and available, the court is prevented from making a long-term order—or any guardianship order at all—notwithstanding the child’s developmental needs and emotional attachments. \(^{244}\)

The Select Committee on Statutory Child Protection and Care in South Australia recently recommended that section 38(2) be expanded in operation to require the court, before making a care and protection order, to be further satisfied that there is no family member able, willing and available to provide care to a child. \(^{247}\) The Commission opposes this recommendation. This suggested amendment would create an even greater obstacle to the court making an order which prioritises the child’s best interests.

The amendments have not made multiple short-term orders unusual. Table 9.13 shows the number of children under a custody or guardianship order at 30 June 2013. 30 June 2014 and 30 June 2015, who were previously the subject of two or more 12-month orders.

Many children are subject to multiple short-term orders. Two or more years may elapse before permanent care arrangements are made, suggesting that reunification is being pursued well beyond the six-to-12-month timeframe supported by research and Families SA policy. The number of such cases has grown by 53 per cent from 2013 to 2015.

Another obstacle to achieving stability for children is the number of cases where Families SA applies for a long-term order, but a short-term order results, whether by a judgement following a trial or a negotiated resolution. From 1 July 2013 to 30 June 2014 Families SA commenced 146 applications for long-term orders. Of these, 21 (14.38 per cent) were finalised by an order other than a long-term order. \(^{248}\)

This proportion grows if matters resolved at trial by judgement only are considered. In the two years from 1 July 2013 to 30 June 2015, the court decided 10 applications for long-term orders by judgment. Of these, three resulted in a short-term order and three resulted in a long-term order that was burdened by a specific access order, an issue discussed below. \(^{249}\)

Some witnesses criticised Families SA and the Crown Solicitor’s Office for not taking a more assertive approach by applying earlier for long-term orders. However, the fact that more than half the applications for long-term orders determined by the court are either unsuccessful or burdened by a specific access order would discourage this.
A study of reunification rates of children who entered care in 2006/07 in Tasmania, Victoria and South Australia found children were considerably slower to be reunified in South Australia. It observed that differences in legislation encourage the court in South Australia:

- to impose two short-term care and protection orders before proceeding to final long-term orders.
- In contrast to some other states, the South Australian Courts appear to place a greater emphasis on giving families an opportunity to resolve their problems before any final decisions are made about children’s long-term future [resulting in] a more gradual exit of children in South Australia.

**INFLUENCE OF THE COURT**

Numerous witnesses from a variety of backgrounds said the Youth Court is reluctant to make long-term orders, preferring to make consecutive short-term orders. There is a perception that the court adopts a ‘strong pro-parent emphasis’, wanting to ‘give parents a go’ and asking ‘what harm does it cause to the child?’ if parents have ‘one more chance’. There is a corresponding perception that the court is reluctant to accept evidence about the effect of attachment disruption on childhood development, a position one witness described as ‘kind of like not believing in gravity’.

Witnesses commented that the court sometimes appeared sceptical about the relevance of parents’ behaviour, including violence, aggression or drug taking, if the child did not witness it. They said the court appeared not to accept that this behaviour might be repeated in the children’s presence, particularly if they were returned to the parents full-time. Marijuana use, in particular, was viewed as less significant. If this is the case, comments from the court to this effect impede the relationship between parents and Families SA, with parents perceiving the court as endorsing their destructive behaviours.

Clearly, much depends on context. The Commission is not able to review the approach taken by the court in individual cases. However, the number of accounts from witnesses of varying backgrounds is cause for reflection.

The court determines only a small number of cases each year. However, its approach in those cases, as well as in the interlocutory stages of cases that are resolved by consent, has a significant influence on decision making throughout the child protection system. The widespread perception that this specialist tribunal gives short shrift to matters as fundamental to child development as attachment theory has the potential to undermine confidence in the court. As discussed above, it is important for the members of the Youth Court, as an expert tribunal, to engage in training that is relevant to child protection.

**THE LEGISLATIVE SCHEME**

While the court is bound to apply the legislative scheme, that scheme offers no explicit recognition of children’s need for timely decision making, stability and the opportunity to form emotional and psychological bonds with alternative carers in the event that their parents cannot care for them. Amendments are needed to refocus decision making in these areas.

Until late April 2016, the objects of the Children’s Protection Act included ensuring that all children are safe from harm and are cared for, as far as practicable, in a way that allows them to reach their full potential. The objects recognised the family ‘as the primary means of providing for the nurture, care and protection of children’ and accorded ‘a high priority to supporting and assisting the family to carry out its responsibilities’.

The Act contained fundamental principles that restated children’s right to be safe from harm. It also explicitly provided for children’s right to be cared for in a safe, stable family environment or, if such an environment could not be provided, in an alternative form of care that would give them every reasonable opportunity to develop to their full potential. These principles, together with the child’s wellbeing and best interests, were described as ‘paramount considerations’.

**Table 9.13: Children under custody or guardianship orders, plus those subject to two or more previous 12-month orders, 2013 to 2015**

<table>
<thead>
<tr>
<th></th>
<th>30 June 2013</th>
<th>30 June 2014</th>
<th>30 June 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children under a custody or guardianship order</td>
<td>2683</td>
<td>2692</td>
<td>2874</td>
</tr>
<tr>
<td>Children under a guardianship or custody order who were the subject of two or more previous 12-month orders (% of total)</td>
<td>121 (4.5%)</td>
<td>166 (6.2%)</td>
<td>185 (6.4%)</td>
</tr>
</tbody>
</table>

Source: Data provided by Families SA.
The Act required that consideration be given to:

- the desirability of keeping the child within the child’s own family and the undesirability of withdrawing the child unnecessarily from a neighbourhood or environment with which the child has an established sense of connection;
- the need to preserve and strengthen relationships between the child, the child’s parents and grandparents, and other members of the child’s family (whether or not the child is to reside with those parents, grandparents or other family members);
- the need to encourage, preserve and enhance the child’s sense of racial, ethnic, religious, spiritual and cultural identity, and to respect the traditions and values of the community into which the child was born;
- if the child is able to form and express his or her own views as to his or her best interests—those views;
- the undesirability of unnecessarily interrupting the child’s education or employment.

The Act also cautioned that children in alternative care must be allowed to maintain relationships with their family (including grandparents) and community to the extent such relationships can be maintained without risk of serious harm. The principles included no recognition of children’s need for timely decision making and stability.

The inquest into the death of Chloe Valentine criticised the Act’s ‘heavy emphasis … on family reunification’ and highlighted the need to act early to save children, by removing them to a safe environment and so preventing cumulative harm in their parents’ care. It recommended amending the Act to make plain that keeping children safe from harm is the paramount consideration and maintaining children with their family must give way to this. It also recommended the inclusion of cumulative harm as a relevant factor in decisions about children’s care.

As a result, Parliament amended the Act to remove the fundamental principles and simplify the objects. The primary object of the Act—and the paramount consideration—is now to keep children safe from harm. Other objects include:

- to ensure as far as practicable that all children are cared for in a way that allows them to reach their full potential; and
- to recognise the importance of families to children and promote caring attitudes and responses towards children among families and all sections of the community so that the need for appropriate nurture, care and protection (including protection of the child’s cultural identity) is understood; risks to a child’s wellbeing are quickly identified; and any necessary support, protection or care is promptly provided.

Decision makers should also consider the views of the child, if he or she is willing and able to express them. While this much shorter list of objects gives prominence to the need for safety from harm, there is no express endorsement of the need to protect children from the harm caused by a lack of stability and permanency planning.

**EMPHASISING PERMANENCE AND STABILITY**

The emphasis on maintaining children in their biological families is not universal among Australian jurisdictions. In other jurisdictions, the permanency and stability of the placement are more important than the biological link between child and caregiver. In New South Wales, for example, legislation enshrines the importance of attachment relationships:

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 permanent placement principles.

Section 9(2)(e) and (g) of the same NSW Act provide that:

- (e) If a child or young person is placed in out-of-home care, arrangements should be made, in a timely manner, to ensure the provision of a safe, nurturing, stable and secure environment, recognising the child’s or young person’s circumstances and that, the younger the age of the child, the greater the need for early decisions to be made in relation to a permanent placement.

- (g) If a child or young person is placed in out-of-home care, the permanent placement principles are to guide all actions and decisions made under this Act (whether by legal or administrative process) regarding permanent placement of the child or young person.

These provisions do not assume that the family (narrowly defined) is the best place to secure children’s best interests; instead, they focus on a stable and secure environment, managed in accordance with permanency planning principles. Where a child’s parents can provide a permanent placement in the child’s timeframe, this is the preference. Where they cannot, an alternative permanent placement should be found. The objects and principles of the South Australian legislation should be amended to align more closely with the NSW model.
In cases where the NSW statutory agency applies for orders for the removal of a child (other than emergency orders), the legislation requires it to assess whether there is a realistic possibility of the child being reunified with his or her parents. In so doing, the agency should consider the child’s circumstances and whether the parents are likely to be able to satisfactorily address the issues that led to the child’s removal.

If the agency determines there is a realistic possibility of reunification, it prepares and submits to the court for its consideration a permanency plan involving restoration, including:267

- minimum outcomes the agency believes must be achieved before the child may safely return to his or her parents;
- details of services the agency could provide or arrange for the child or the parents to facilitate reunification;
- details of other services the court could request that other government or non-government agencies could provide;
- a statement of the length of time during which restoration should be actively pursued.

If the agency determines there is no realistic possibility of reunification, it prepares and submits to the court for its consideration a permanency plan involving restoration, including:267

- minimum outcomes the agency believes must be achieved before the child may safely return to his or her parents;
- details of services the agency could provide or arrange for the child or the parents to facilitate reunification;
- details of other services the court could request that other government or non-government agencies could provide;
- a statement of the length of time during which restoration should be actively pursued.

Critically, ‘realistic possibility’ of reunification is not an open-ended timeframe. For a child less than two years of age when the court makes its interim order, there must be a realistic possibility of reunification within six months. For older children, the timeframe is within 12 months.268

These timeframes are consistent with evidence about the need for stability and permanence. They focus the minds of families, the statutory agency and other support workers on achieving reunification within a defined period. The evidence indicates that most parents who can address their problems will do so in this timeframe. A child should not be left to wait indefinitely for those who cannot.

The reform measures outlined in Chapter 8 and in this chapter should help the Agency to identify and respond to family problems much earlier than is currently possible. Concerns that require a statutory response should also be identified earlier. The Agency would have additional powers to seek information, allowing earlier, more comprehensive assessments and the targeting of more intensive support. Earlier responses would also permit Family Care Meetings to be used as intended, giving families (including extended families) a genuine opportunity to develop plans to care and protect their children.

Where court orders are needed, the Agency would generally commence investigation and assessment proceedings to protect the child for up to six to 10 weeks while further expert assessment occurred. If, after the assessment process the child remained at risk, the Agency would commence care and protection proceedings. The Agency would be required to assess at this time whether there is a realistic possibility of reunification in the relevant timeframe—six months for children under the age of two years and 12 months for older children. If it assessed that there was a realistic possibility of reunification, the Agency would seek a short-term order of either six or 12 months. If not, the Agency would seek a long-term order until the child turned 18 years. In most cases, at this point there would be caution optimism for reunification, if the parents were responding to the offered support.

The Agency would be required to prepare and submit a permanency plan to the court within four weeks of filing its care and protection application. In cases where it assessed there was no realistic possibility of reunification in the timeframe, the permanency plan would propose an alternative long-term option. In cases where there was a realistic possibility of reunification, the plan would set out how this would be achieved, including the four matters listed above from the NSW scheme.

If the court were to accept the permanency plan and the parties consented to it, the court could then make final orders. If the court was not prepared to accept the permanency plan, it could direct the Agency to prepare and submit another plan.

In reunification cases, the response of the family, the Agency and the reunification service providers would need to have regard for the child’s short developmental window. The Agency should expeditiously refer families to a reunification service provider, who in turn should promptly engage the family, according to the permanency plan. Parents should take the steps required to resume care of their children within the stated timeframe.

The reunification service provider should also provide regular, frank reports to the Agency to allow it to make proper, ongoing assessments of whether there remained a realistic possibility of reunification within the relevant timeframe.

If this possibility evaporated at any point, the Agency should commence proceedings for long-term orders and submit a new permanency plan no later than four weeks thereafter. The court would then determine whether it accepted the Agency’s assessment. The legislation should expressly state that a parent’s failure to comply with his or her commitments in the permanency plan is relevant to this decision.
In rare, exceptional circumstances (most likely to arise for older children) the court would have the discretion to extend the relevant timeframe for up to six months. In such cases, the onus should be on the parties to demonstrate why it would be necessary to extend the timeframe, having regard to the child’s best interests, including the potential risk this poses to the child’s need for stability and permanence.

Figure 9.2 shows how intervention by support agencies and the Agency could escalate to support families and to promote safety, stability and permanence.

**PROMPT COURT DETERMINATIONS**

An obstacle to finalising arrangements more quickly for children is the time taken to determine contested applications. The Act requires trials to start within 10 weeks of lodging a care and protection application and to be heard expeditiously. There is no time limit for a trial to be finalised.270

Because many trials are resolved by consent on the first hearing day, the Commission understands that the court schedules trials for a single day, with an opening address from Families SA’s counsel and some initial evidence.271 This is a pragmatic approach. However, the balance of the hearing can extend over many months, with a series of one or two hearing days interspersed by long adjournments.272

The Commission reviewed nine care and protection judgments decided by the court between 1 July 2013 and 30 June 2015 where the dates of both application and judgment could be ascertained. One judgment was delivered 1176 days after the filing of the application. Although that case was unusual as there was a delay to allow the father’s criminal charges to be finalised, there were still 392 days between listing the matter for hearing and the final judgment. The remaining eight cases were determined in an average of 200 days (more than six months) after the application was filed. Two of these were applications for long-term orders, where the court took 356 and 325 days respectively to grant short-term orders so that reunification efforts could continue. Lengthy delay in pursuing reunification is particularly unfortunate.273

It is curious to require trials to start quickly, yet allow them to be heard in short bursts over an extended period. Ten weeks can be a very short time to commence important proceedings and in some cases it may mean the court does not have all the relevant information to make the best decision.274 However, short timeframes for achieving either reunification or an alternative permanent placement mean contested matters should be resolved quickly.

At present, trials are relatively rare and the Commission’s recommendations may further reduce them. Under the proposed changes, in most cases the Agency would initially seek a short-term order and then pursue reunification with guidelines in the permanency plan as to what is expected. Except where parents dispute the need for a guardianship order at all, most parents would support this approach. If reunification were unsuccessful within the relevant timeframe and the Agency returned to court for long-term orders, the legislative scheme would emphasise the need to provide children with stability and there would rarely be a basis to extend the timeframe for reunification.

![Figure 9.2: Processes for promoting safety, stability and permanence](image-url)
The Act should be amended to remove the specific requirement to commence trials within 10 weeks, but it should continue to require the court to hear and determine proceedings as expeditiously as possible. It may be appropriate to call the case on for a listing conference before fixing a date for trial, but once the trial commences, without special reasons, it should continue until the conclusion of evidence with the judgment delivered as soon as practicable thereafter.

The recommendations in this chapter with respect to reducing timeframes to promote stability and permanency may have a significant impact on the number and type of matters that proceed to trial and, as a result, may require a review of listing arrangements.

**CONCURRENT PLANNING**

In most cases where Families SA commences care and protection proceedings there is usually a realistic possibility of reunification. As reunification work proceeds according to the proposed permanency plan, some parents are unable to address their problems in the timeframe that their children require. To meet this reality and to avoid putting children’s lives on hold, practitioners should prepare either the child’s return to their biological parents or their placement in stable, alternative care. The term ‘concurrent planning’:

Refer to case management that comprises a family reunification case plan being pursued, while at the same time developing an alternate plan for permanent care. If the case goal changes, the alternate plan is already in place. Concurrent planning is designed to reduce case drift and to give children stability as early as possible.275

Families SA policy supports concurrent planning to ‘reduce the time that children have to wait before longer-term plans can be made’.276

One form of concurrent planning is to recruit foster parents who are prepared to support the reunification process, caring for the child in the interim period, and to care for the child long-term if reunification is unsuccessful. This is emotionally demanding on foster parents, particularly where reunification is pursued indefinitely, as it requires them to love and commit to children who may or may not remain permanently in their care. While concurrent planning promises to avoid putting children’s lives on hold277, in reality children and foster parents inevitably hold back emotionally when care arrangements remain uncertain.278 The emotional toll of this uncertainty makes it difficult to recruit foster parents and contributes to placement breakdown.279

The specific timeframes for reunification proposed above should significantly improve concurrent planning in practice and more clearly define the period of uncertainty.

**FAMILY CONTACT**

It is usually in the interests of children in care to continue to have some contact with their parents and siblings.280 However, contact should be a high-quality, shared experience for parents and children to promote the broader plans for the child and his or her development. If pursued incorrectly or for the wrong reasons, contact can undermine children’s development, in particular in relation to their need for stability and permanancy.

Before the Act was amended in 2016, the fundamental principles required that children placed, or about to be placed, in alternative care should be allowed to maintain contact with their family, to the extent that contact could occur without a ‘serious risk of harm’.281 This put too much emphasis on family contact by tolerating a level of risk to the child. The recent amendments to the Act do not address the issue.

**CONTACT FOR THE RIGHT PURPOSE**

The purpose of family contact depends on the child’s circumstances, that is whether the plan is to pursue reunification or to invest in a stable, alternative placement. Where reunification is being pursued, contact aims to establish and maintain attachment relationships with biological parents to support the child’s eventual return.282

Where the plan is not to reunify, children need to form new attachments with long-term carers. Contact should not, therefore, aim to maintain an attachment relationship with parents. Instead, contact should maintain a ‘knowledge link’ with parents, helping children integrate their parents in their mind as they grow and to view them realistically, neither as a continuing threat nor as idealised figures.283 Too frequent contact in such cases can undermine the bond with new carers by raising doubt in children’s minds as to whether the placement will last and whether they should prepare emotionally to return to their parents.284

**FREQUENCY OF CONTACT**

Where reunification is envisaged and the aim is to rebuild children’s attachment to their parents, contact needs to be more frequent than where it only aims to maintain a knowledge link. But care should be taken to ensure that contact does not overwhelm other aspects of the child’s life. A secure attachment relationship helps children to develop other attachments. If contact arrangements:

Undermine an infant’s relationship with their current carer, or are undertaken in conditions that do not ensure the infant has access to someone in their hierarchy of attachment figures available to help them regulate their emotions and behaviour, visits may in fact undermine the very goal they are trying to achieve (i.e. eventual reunion with the parents or a meaningful relationship with them while the child is in out-of-home care).285

9 INTERVENTION WHERE THERE IS IMMINENT RISK
Frequent contact has practical challenges. It is important for infants and small children to maintain sleep and feeding routines. Being woken and strapped into a car seat for up to an hour in each direction to attend contact visits disrupts routines and can be stressful. The effects can last long after children settle into long-term placements. Frequent contact that disregards the children’s needs and routines is likely to be less satisfying for children and parents. If contact is to improve attachment relationships, it should be arranged so:

*Children feel as secure as possible, alert, awake and happy in order for them to have the curiosity and emotional energy to invest in getting to know and to interact with their parents.*

Older children also have busy lives, including school, extracurricular activities, health appointments, socialising with friends and participating in the rituals of their new family. Frequent contact can cause them to miss out on these opportunities and undermine their sense of normality. Contact that disrupts education is a particular problem for children who enter care with educational deficits.

Frequent contact can also be difficult for biological parents to sustain while also attending assessments, counselling or treatment to address their problems. Frequent contact is sometimes viewed as promoting reunification. However, the evidence in this regard is mixed. A study of Victorian infants in care found that high-frequency contact schedules (four to seven visits per week) were not associated with increased rates of reunification one year later. While some research shows a relationship between more frequent contact and reunification, this link is correlative not causative and contact is only one factor among many others in reunification.

**PROMOTING THERAPEUTIC CONTACT**

Contact is a therapeutic opportunity to repair child-parent relationships and to build parenting skills. However, parents are often only offered limited support. Access facilities and transport options also impede high-quality shared time.

One option is to hold contact in supported playgroups in Children’s Centres. These playgroups offer a more natural, supportive environment for contact with children in care, allowing parents to interact with their children, make friends and receive practical advice and support. Many of the playgroups are run by family service coordinators (FSC), who are usually trained social workers with experience in working with vulnerable families.

Families SA usually sends an access worker to supervise contact with children in care at playgroups. This is probably unnecessary where an FSC is present. With appropriate guidelines and support, FSCs should be able to supervise contact and to report progress to the Agency. To this end, contact in supported playgroups should be expanded and guidelines developed to allow FSCs to supervise where appropriate.

The person charged with supervision of the contact should be mindful of the active nature of the role. They should observe, assist, coach, intervene when necessary, and record observations and activities.

Contact spaces in Families SA often leave much to be desired: sterile office-like spaces, sometimes doubling as meeting rooms, with few toys or facilities to promote normal, positive interactions.

Contact visits are sometimes held in more natural environments, such as community facilities including parks, libraries and play cafés. Where appropriate, these environments should be chosen to encourage more natural, positive parent-child interactions. However, in some cases, safety and supervision requirements mean contact cannot be held in the community. For this reason, the Agency’s offices should have dedicated spaces for contact, with facilities therapeutically designed to promote high-quality time.

Many children travel long distances to contact visits, some further than their parents. In the case of Abby (see Vol. 2, Case Study 2), she was less than 12 months old and was being cared for in highly unsuitable rotational care arrangements when her caseworker declined two foster care placement offers because they would involve excessive travel for contact with Abby’s mother. The caseworker responded to a suggestion that the mother should travel to Abby by saying that this would be too stressful and time consuming given other demands on the mother’s time.

Children are routinely transported to contact visits by workers or volunteers who are effectively strangers. This can be ‘an experience of emotional abandonment’, leaving children:

*To their own emotional resources to manage the emotions evoked by separation from their carer, being accompanied by an unknown adult, travel, reunion with parents, interaction with parents, separation from parents, travel home again with unknown adult and reunion with their foster carer.*

Rather than being a positive, shared experience, contact in these circumstances is ‘likely to be highly stressful, counterproductive and, in fact, damaging’.
The Agency should review how it transports children to contact. Parents should generally be expected to travel to minimise travel by children. An exception might be where the child is spending an extended period of time in the parent’s care as part of the reunification plan. Ideally, children should be transported by their foster parents, although this will not always be a practical or safe option. In all cases, children should be transported to contact by people they know and trust.

AVOIDING HARMFUL CONTACT

For some children, contact is harmful. It can reactivate and perpetuate past trauma for children who have been assaulted by their parents. This risk is amplified when contact occurs in the absence of the child’s primary caregiver. Expert therapeutic advice should be sought to weigh the benefits of contact for such children.

Young children are sensitive and perceptive. Even if they are too young to understand what is said, contact with a very disturbed, hostile, harsh, belittling or vengeful adult will have an emotional impact. Research shows babies are frightened by parents who present a ‘scary face’. Well-trained practitioners should be able to identify where children feel distressed, including identifying their non-verbal cues.

Reports by carers of signs of apparent trauma before and after access are too often ignored. This destabilises the formation of an attachment between children and their carers. Children look to carers to protect them from scary situations and are confused when they do not. This puts carers in an invidious situation, unsure whether to intervene or hold back.

Children’s fundamental right to safety from harm extends to safety from harmful contact with their family. Children in the care of the state need to know that the caring adults around them will see and hear their distress and will protect them from harmful experiences. Practitioners involved with the child should be trained to recognise potential signs of distress, including in non-verbal children. If children experience trauma during contact or show signs of distress or anxiety, then contact should cease and only resume subject to expert, therapeutic advice.

Nathan (see Vol. 2, Case study 4) entered care at 18 months following horrific abuse at the hands of his mother. For two years, Families SA pursued reunification, exposing Nathan to further trauma during contact. For example, his mother threw Nathan onto a couch and verbally abused him. At a later contact, his mother said ‘fucking get into bed’ and threw him roughly to the ground. Nathan showed signs of significant distress.

His experiences left Nathan uncertain about his safety at each contact and to whose home he would return:

When children don’t feel safe, they’re wondering, ... When is the next access visit coming? What will she be like when I attend? It keeps them focused on their safety and not focused on the things that they should be doing as little people—learning, establishing relationships, focusing on all the things that support their more general learning.

These events had a lasting effect on Nathan’s capacity to develop attachment relationships and to settle into home-based placements.

The Commission also heard evidence with respect to a 10-year-old foster child whose mother abused him during telephone contact. Families SA insisted that contact continue despite repeated statements from the child that it was not what he wanted.

MORE FLEXIBLE CONTACT ARRANGEMENTS

Contact arrangements need to be flexible enough to adapt to the changing needs of children. In South Australia, the court determines contact arrangements. In most cases, particularly where the case is resolved by consent, the court makes a general access order, which means the child must have contact with the mother or father at such times, dates and places as may be agreed between parents and Families SA, and supervised at the discretion of Families SA. This is a somewhat curious order, because in practice it permits Families SA to determine the terms of contact.

By contrast, if the case is contested and the court makes orders after a trial, it often makes a specific access order, which specifies the frequency and duration of access. If the child’s circumstances change and the specific order is no longer in the child’s best interests, a further application may be required to vary the order. This is particularly problematic where the court makes a specific access order and a long-term order, because the child’s needs are almost certain to change across the life of the order. In some cases, the court mandates relatively frequent, long-term contact: as much as once or twice a week. This represents a significant burden on the long-term order because it undermines the stability and permanence of that arrangement.

Whether the order is specific or general, it requires at least some level of contact, even if the child exhibits signs of distress that indicate contact should cease for a time. The order places significant pressure on Families SA to continue to present the child for contact even if it appears not to be in the child’s best interests, including where parents’ attendance is poor (leaving children to wait forlornly for parents who do not attend) or where parents attend under the influence of drugs or alcohol or behave aggressively or erratically. In the case of Abby, contact between the infant and her mother proceeded even when the mother attended under the influence of drugs.
The court’s preference for frequent contact—up to daily contact for some small infants—also places pressure on Families SA practitioners to offer frequent contact even in cases where the court does not formally order it.

Contact is frequently a negotiation tool in contested cases, with parents arguing for more frequent contact before agreeing to a custody or guardianship order:

*Families SA will often agree to these terms because making concessions on contact secures a safe, permanent and stable environment for the child while avoiding the uncertainty in what is often a lengthy trial. While this approach makes practical sense and is entirely understandable, it brings with it a subtle shift away from the best interests of the child and towards the interests of the parents. In other words, it becomes more about when, where and how often the parents want to see the child, rather than what orders and access arrangements are in the best interests of the child.*

The court’s power to impose contact orders also leads to a practical consideration: where children move interstate and orders need to be transferred to another jurisdiction, the case must return to court to remove the order for contact before transfer.

There are effectively two processes for providing contact. Where the custody or guardianship order is made by consent, Families SA determines contact with no external oversight. Where the order is contested, the court fixes contact arrangements once and for all. It is hard to justify this distinction, which arguably gives parents a perverse incentive to contest applications.

While the court should retain power under section 38(1)(e) to direct a party to refrain from having contact or residing with, or coming within a specified distance of, the child, its power under section 38(1)(f) to make orders for contact with the child should be repealed. Instead, the Act should provide the Agency with the discretion to determine contact arrangements, having regard to the best interests of the child. In most cases, this would be determined at the local level by the Agency’s caseworkers and their supervisors, in consultation with other practitioners involved with the family, in particular any reunification service providers.

Disputes will arise from time to time. If the Agency is to determine contact arrangements, it is particularly important that they reflect the best interests of the child and not resource issues in the Agency. The permanency plan submitted to the court should include a process for resolving disputes concerning contact, prioritising early mediation where possible.

For cases where mediation is unsuccessful, a standing expert Case Review Panel (CRP) should be developed in the Agency. The panel should have three members, with the chairperson and the majority of members independent of the Agency. The members should have the skill and expertise to review contact arrangements and to direct changes where required. All members of the panel should be independent of the case being considered. The panel should aim to review arrangements quickly and with a minimum of formality. Its decision would be final, unless there was a significant change in circumstances, in which case a matter might be reconsidered. A child’s biological parents and current foster parents should have standing to use these processes. In appropriate cases, the child who is the subject of the dispute should also have the right to make application to the panel and to be heard in any dispute.
The Commission recommends that the South Australian Government:

57 Review procedures for strategy discussions to ensure they are convened promptly upon the receipt of notifications requiring investigation (and without delay when children present with physical injury). Discussions should include all relevant government and non-government participants and be re-convened as necessary.

58 Provide the Agency’s practitioners with training, support and supervision to equip them to make realistic assessments of risks, particularly in areas of chronic maltreatment, cumulative harm, social isolation, drug and alcohol abuse, mental health, family violence, and attachment and care needs of young children, to consider the views of children and to develop appropriate safety plans.

59 Reconcile and integrate the Agency’s assessment tools and documentation (including Solution Based Casework™, the assessment framework and decision-making tools).

60 Amend section 20 of the Children’s Protection Act 1993 to delete section 20(2) and (3), and include a provision which empowers the Agency to issue a written direction to parents, guardians or other persons requiring them to submit to a drug and alcohol assessment, with the results to be provided to Families SA.

61 Ensure the Agency responds to all screened-in notifications, either directly, or by appropriate referral, including responding promptly (including after hours) to notifications in which physical injuries are notified and the Agency’s assistance is required to facilitate a forensic medical assessment.

62 Phase out the closure of intakes and files due to a lack of resources. This should occur over a period of no more than five years from the date of this report. In the interim, practitioners should be provided with clear guidelines as to the circumstances in which such closures are appropriate. There should be quarterly reports to the public on the rate of closures that are due to a lack of resources.

63 Amend section 19(1) of the Children’s Protection Act 1993 by deleting section 19(1)(b) thereof to provide that:
   a if the Chief Executive suspects on reasonable grounds that a child is at risk, the Chief Executive must cause an assessment of, or investigation into, the circumstances of the child to be carried out or must effect an alternative response which more appropriately addresses the potential or actual risk to the child.

64 Ensure that the Agency focuses on case management of protective intervention cases and that not-for-profit agencies provide direct service delivery to families. All protective intervention programs should be evaluated on a regular basis to ensure that all such programs have an established evidence base.

65 Establish a Child Protection Service (CPS) unit at the Lyell McEwin Hospital.

66 Amend the Children’s Protection Act 1993 to provide an independent model of expert assessment in similar terms to the Children’s Court Clinic in New South Wales.

67 Amend the Children’s Protection Act 1993 with respect to the procedures relating to Family Care Meetings (FCMs) as follows:
   a amend section 27(1) to provide that the Agency should consider causing an FCM to be convened whenever it is of the opinion that a child is at risk but the risk appears capable of being addressed at an FCM;
   b repeal section 27(2);
   c amends 36(6) to provide that an FCM decision would not be valid without the agreement of the relevant members of the family and the Agency;
   d require the Agency to give effect to FCM decisions, unless they are impracticable or inconsistent with the principles of the legislation, in which case the FCM should be reconvened or proceedings commenced in Court; and
   e require FCM decisions to be reviewed after three months, but provide that any party to the decision may request an earlier and/or subsequent review, if required.
Review procedures and funding arrangements for the Youth Court Conferencing Unit:

a to enable the Unit to recruit and train a panel of child advocates for Family Care Meetings (FCMs)—advocates should hold a valid child-related employment screening clearance; and

b to consider whether in an appropriate case a child’s foster parent should be invited to an FCM.

Amend the Children’s Protection Act 1993:

a to require the child’s lawyer to:

i act in accordance with the child’s instructions to the extent the child is able and willing to give such instructions

ii supplement those instructions with his or her own view of the child’s best interests to the extent the child is not able and willing to give instructions (provided the lawyer’s views do not contradict any instructions the child is able and willing to give)

iii indicate the nature of the role to the child, in accordance with the child’s developmental capacity

iv indicate to the court on which basis submissions are made; and

b permit the court to appoint a child’s representative or, in emergencies, to dispense with the need for a representative. In the latter situation, the court should only make interim orders and then adjourn the proceedings to enable a duly instructed lawyer to represent the child.

Amend the Children’s Protection Act 1993 as follows:

a repeal section 38(1)(a) which concerns the making of orders for supervision and undertakings and section 38(2)(a);

b include as an object in the Act the importance of timely decision making to promote stability and maintenance for a child;

c at the time of the commencement of care and protection proceedings the Agency should assess whether there is a realistic possibility of reunification:

i within six months for a child under two years, or

ii within 12 months for a child over two years; and

d if there is a realistic possibility of reunification within the timeframe specified in Recommendation 70(c), the Agency should seek an order placing the child under the guardianship of the Minister for a period of either six or 12 months (depending on the age of the child), and file a permanency plan setting out the proposals for reunification;

e if at the commencement of care and protection proceedings, or at any time thereafter, there does not appear to be any realistic possibility of reunification within the timeframe specified in Recommendation 70(c), the Agency should immediately apply for an order placing the child under the guardianship of the Minister until the age of 18 years and file a permanency plan setting out the proposals for the long-term placement of the child;

f if at any time special circumstances arise (particularly with respect to an older child) which make it necessary to extend the timeframes set out in Recommendation 70(c) hereof the Court shall have the discretion to extend the timeframe for a period no longer than six months. In any such case the onus will be on the parties to demonstrate the need for such extension having regard to the child’s best interests and the potential risk to the child’s need for stability and permanence;

g amend section 39(a) to delete the requirement to commence a hearing within 10 weeks, but provide that all proceedings be heard and determined expeditiously and that once the hearing commences, without special reasons, it should continue until the conclusion of evidence with the judgement delivered as soon as practicable thereafter.
71 Encourage lawyers employed by the Legal Services Commission and the Crown Solicitor’s Office to undertake child protection training and require lawyers engaged through the Legal Services Commission to represent children in state child protection proceedings to hold a valid child-related employment screening clearance.

72 Ensure that contact arrangements meet the changing needs of children with respect to such matters as venue, transport arrangements and supervision and that contact never occurs when the parent is or is suspected of being affected by drugs and/or alcohol.

73 Amend the Children’s Protection Act 1993 to exclude contact arrangements from orders of the court and require all contact arrangements be referred to the Agency for determination in accordance with the best interests of the child. The permanency plan filed at court should include a provision as to the resolution of contact disputes, including mediation procedures wherever possible.

74 Establish an independent standing expert Case Review Panel to review the issue of contact when mediation is unsuccessful and it is necessary to resolve any dispute as to contact arrangements.
INTERVENTION WHERE THERE IS IMMINENT RISK

The source is known to the Commission, and is identified by a number in the endnotes.

Some oral evidence, witness statements and submissions were received on a confidential basis.

NOTES

1 Children's Protection Act 1993 (SA), s. 19(1).
3 ibid., p. 8.
4 Children's Protection Act 1993, s. 19(2).
5 ibid., ss. 19(3) and (4).
7 Children's Protection Act 1993, s. 20(1).
8 ibid., s. 21(1).
9 ibid.
10 ibid., s. 38.
12 Oral evidence: S McEwen.
13 A 'protection order' includes a range of child protection court orders, including supervision, custody and guardianship orders; Children, Youth and Families Act 2005 (Vic), ss. 196, 275.
18 SA Police convene Strategy Discussions for extra-familial matters.
19 Child Protection Services at the Women’s and Children’s Hospital and the Flinders Medical Centre perform forensic medical assessments and forensic interviews of children.
24 Oral evidence: B Sawyer; L Balmer.
29 Oral evidence: D Christensen. DN Christensen et al., Solution-Based Casework, pp. xii, 62.
31 Oral evidence: Name withheld (W29).
33 Oral evidence: D Christensen.
34 Oral evidence: R Starrs; D Christensen; S Macdonald.
35 Oral evidence: D Christensen; S Macdonald.
37 ibid., p.2.
44 Under a Voluntary Custody Agreement, guardians of a child agree to transfer custody of the child to the Minister for up to two consecutive three-month periods, Children’s Protection Act 1993, (SA) s. 9.
51 Coroner's Court of South Australia, Finding of the inquest into the death of Valentine, Chloe Lee, Inquest number 17 of 2014, pp. p. 41.
52 Coroner's Court of South Australia, Finding of the inquest into the death of Napier, Ebony Simone, Inquest number 16 of 2015, pp. 105–6, 124.
54 ibid., pp. 16, 121–2.
55 Oral evidence: S Smith; C Keogh.
9 INTERVENTION WHERE THERE IS IMMINENT RISK

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57 Talking with children is different to child interviewing, which is a specialist skill that most Families SA workers do not require given the specialist role played by Child Protection Services.

58 Oral evidence: S Macdonald.

59 Oral evidence: J Edwards. Witness statements: Name withheld (S68); L Williamson.

60 Oral evidence: Name withheld (W96).

61 Oral evidence: S Macdonald; name withheld (W96).

62 Oral evidence: S Macdonald; D Christensen.

63 Refer to EN 51, pp. 21, 103–4.

64 Oral evidence: S Macdonald.


67 ibid., p. 20.

68 Yaitya Tirramangkotti, a unit formerly based at the Families SA Call Centre dedicated to Aboriginal and Torres Strait Islander children, could recommend a home visit. Families SA, ‘Child protection manual of practice, vol. 1’, pp. 142–3, 146.

69 Oral evidence: F Arney; K Taheny; S Macdonald.


71 Submission: Child Death and Serious Injury Review Committee.


73 RA Layton (Chair), *Our best investment*, p. 9.23–4.

74 Data provided by Families SA. Excludes extra-familial notifications, which are referred to SA Police for response.

75 Oral evidence: K Taheny.

76 Oral evidence: C Keogh.


78 Oral evidence: Name withheld (W58).

79 Oral evidence: K Taheny.

80 Oral evidence: Name withheld (W58).

81 O Octoman & L Bromfield ‘Children at risk of repeated involvement with child protection services: A longitudinal study using child protection data’ presentation, Australian Centre for Child Protection, no date.


83 Oral evidence: K Taheny.

84 *Children’s Protection Act 1993*, (SA) s. 19(1).

85 ibid, s.14(b).

86 Refer EN 51, p. 112.

87 Oral evidence: R Croser.

88 Oral evidence: Name withheld (W61).

89 Oral evidence: C Simmons.


93 Oral evidence: Name withheld (W16).

94 Oral evidence: Name withheld (W16); name withheld (W78).


96 Oral evidence: Name withheld (W61).

97 Oral evidence: C Pearce.

98 Oral evidence: S McEwen.

99 ibid.

100 ibid.


102 *Children and Young Persons (Care and Protection) Act 1998* (NSW), Division 6, Part 1, Chapter 5.


104 Oral evidence: C Pearce.


108 Oral evidence: Name withheld (W61).

109 This program was formerly known as Stronger Families, Safer Children.

110 Oral evidence: L Haddad. Targeted intervention services respond to moderate risk families referred directly by an assessment and support team.


112 Oral evidence: Name withheld (W28).


116 Oral evidence: K Drew; S Hoffman; S Macdonald; name withheld (W8).

117 Oral evidence: F Arney; L Haddad; S Macdonald.
The source is known to the Commission, and is identified by a number in the endnotes.

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9 INTERVENTION WHERE THERE IS IMMINENT RISK

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161 Data provided by the Conferencing Unit, Youth Court of SA.
163 Oral evidence: M Radhakrishnan.
164 Oral evidence: Name withheld (W58); name withheld (W35); name withheld (W45); name withheld (W4); M Hood. Witness statement: Name withheld (W85).
165 Submission: Conferencing Unit, Youth Court of SA.
166 RA. Layton (Chair), Our best investment, Recommendation 117.
168 Oral evidence: Name withheld (W45); also M Hood.
169 Oral evidence: C Doherty; M Radhakrishnan.
170 Oral evidence: M Radhakrishnan.
171 Children’s Protection Act, s. 32(6).
172 Submission: Conferencing Unit, Youth Court of SA.
174 Submission: Conferencing Unit, Youth Court of SA, Families SA, ‘Options paper: Reclaiming Family Care Meetings’, pp. 4–5.
175 N Harris, Family group conferencing, p. 14; Children, Young Persons, and Their Families Act 1989 (New Zealand), s. 31; see also M Ivec, A necessary engagement, p. 33.
176 FGDM, Guidelines for family group decision making, p. 1.
177 ibid., p. 14.
178 ibid.
179 Oral evidence: Name withheld (W35).
180 F Arney, K McGuinness & M West, Report on the implementation of family group conferencing, pp. 8, 42–3.
181 Children, Young Persons, and Their Families Act 1989 (NZ), s. 34.
182 Oral evidence: R Croser; also name withheld (W4).
183 Submission: Conferencing Unit, Youth Court of SA.
184 Oral evidence: R Croser.
185 Submission: Conferencing Unit, Youth Court of SA.
187 Children’s Protection Act 1993, s. 30(2).
188 Oral evidence: C Doherty.
189 Oral evidence: C Doherty.
190 ibid.
191 Oral evidence: R Croser.
192 Children’s Protection Act, ss. 29(2), 30(1)(e).
194 FGDM, Guidelines for family group decision making, pp. 30–1.
195 Children’s Protection Act, s. 9.
197 Children’s Protection Act, s. 21.
198 Oral evidence: S McEwen. The Crown Solicitor’s Office (CSO), provided data to the Child Protection Systems Royal Commission. Includes matters where Families SA gave instructions to commence proceedings between 1 July 2013 and 30 June 2014 which sought a custody order under s. 20 of the Children’s Protection Act.
199 Children’s Protection Act, s.16(1). A police officer may also exercise this power.
200 Children’s Protection Act, ss. 16, 20–1.
201 Data provided by the Crown Solicitor’s Office, Attorney-General’s Department, Government of South Australia.
202 Children’s Protection Act, ss. 37, 38.
204 Children’s Protection Act, s. 48(1).
205 Oral evidence: R Croser; name withheld (W4).
206 Children’s Protection Act, s. 48(2).
207 Oral evidence: R Croser; name withheld (W4).
208 Family Law Act 1975 (Cth), s. 68LA.
209 Children, Youth and Families Act 2005 (Vic), s. 524. In exceptional circumstances, a lawyer may represent younger children and those not mature enough to instruct a lawyer. In that event the lawyer acts in accordance with what he or she believes to be in the best interests of the child and communicates, to the extent that it is practicable, the instructions given or wishes expressed by the child: s. 524(1).
212 ALRC, Seen and heard, para. 13.74.
215 ibid., para. 13.52.
217 ibid., para. 13.56.
218 ibid., para. 13.53.
219 ibid., para. 13.80.
221 ALRC, Seen and heard, para. 13.81.
224 Oral evidence: R Croser.
INTERVENTION WHERE THERE IS IMMINENT RISK

Some oral evidence, witness statements and submissions were received on a confidential basis.


RA Layton (Chair), Our best investment, Recommendations 113.


Oral evidence: Name withheld (W4).


Our best investment, Recommendations 113.

Oral evidence: Name withheld (W4).


Current language obscures the focus on contact of children. The Act permits the Court to make orders ‘providing for access to the child’: Children’s Protection Act 1993 (SA), s. 38(1)(f). Family contact is commonly called ‘access’ in South Australia. This presents ‘contact’ as something parents get to gain access to their children, rather than shared time to promote the child’s wellbeing. The Commission prefers the term ‘contact’.

Children’s Protection Act, s. 4. This section has since been amended.

Oral evidence: J Beal.


Y Gauthier, G Fortin & G Jeliu ‘Clinical application of attachment theory’, p. 379.


9 INTERVENTION WHERE THERE IS IMMINENT RISK

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288 A key concern of children in care is to be treated ‘like normal kids’: GCYP, What children say about child protection, p. 6.
293 In late 2015 there were 42 Children’s Centres or Children and Family Centres in South Australia (discussed in Chapter 8).
294 Oral evidence: Name withheld (W25).
295 ibid.
296 Oral evidence: Name withheld (W61), J Beall. Also, the Commission’s observations of access facilities.
298 Oral evidence: K Moulden.
300 ibid., pp. 1, 18.
302 Oral evidence: R Croser.
304 ibid. Also oral evidence: J Beall.
305 Oral evidence: J Beall.
307 Oral evidence: J Beall.
308 Oral evidence: C Simmons.
309 ibid.
310 Oral evidence: Name withheld (W112).
311 Oral evidence: R Croser; S McEwen.
312 More than half (55.56 per cent) of judgements arising from child protection proceedings commenced by Families SA in 2013/14 included specific access orders; data provided by the Crown Solicitors Office.
314 Oral evidence: J Beall.
315 Contact orders for older children are sometimes expressed to be ‘subject to the wishes of the child’.
316 Oral evidence: J Beall.
317 Oral evidence: Name withheld (W61).

Some oral evidence, witness statements and submissions were received on a confidential basis. The source is known to the Commission, and is identified by a number in the endnotes.