Healthcare that counts

A framework for improving care for vulnerable children in Victorian health services

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Foreword

To secure safety for children, and to deliver care that meets the needs of vulnerable children, all health services must work together with families, family support services, child protection and the justice system to achieve the best possible outcomes.

Healthcare that counts: A framework for improving care for vulnerable children has been developed to support all Victorian health services strengthen their response to vulnerable children and drive system-wide improvements to deliver coordinated and high quality care.

We know that children's health and wellbeing is harmed by events like family violence, child abuse and neglect. That is why identifying, protecting and supporting vulnerable children, their families and carers is a priority for the Department of Health and Human Services and the Victorian Government.

Roadmap for Reform: Strong Families, Safe Children recognises the critical role that mainstream health services play in supporting children, families and their carers. The Royal Commission for Family Violence recognised that health professionals are in a unique position to identify and respond to family violence. Our health system's role is crucial in responding to vulnerability because it can provide earlier and more connected care. This type of care is critical if we are to protect and promote children's health, safety and wellbeing.

Healthcare that counts now applies to all Victorian health services - whether an acute hospital, community health service, alcohol and drug service, aboriginal health service, mental health service or community service funded to provide health programs. All health services must be able to demonstrate ways that their service is strengthening best practice in responding to vulnerable children.

By defining best practice and quality measures, *Healthcare that counts* supports all health services, to have a stronger focus on vulnerable children and families.

The intent of *Healthcare that counts* is to complement and enhance existing standards, accreditation performance and monitoring processes used by health services. This includes aligning with and reinforcing mandatory *Child Safe Standards*. I know that there are many examples where health services deliver best practice approaches for vulnerable children. I am pleased that *Healthcare that counts* shares these and other resources to support implementation.

By fulfilling our important responsibility to deliver care that protects and promotes the needs of vulnerable children, we can help improve their lives so that they can reach their full potential. *Healthcare that counts* will support this role and ensure that child safety, health and wellbeing is the business of every health service and health professional throughout the Victorian health system.

I look forward to working with you as we strive to deliver the best possible care for vulnerable children and their families.

Kym Peake
Secretary
Department of Health and Human Services

A framework for improving care for vulnerable children

Background

Healthcare that counts: A framework for improving care for vulnerable children articulates the role of all Victorian health services in the early identification and effective response to vulnerable children at risk of child abuse and neglect.

The Victorian health system is supporting disadvantaged Victorians who present with a mix of health issues and complex social needs, such as family violence, mental health issues, alcohol and drug misuse, social exclusion and financial disadvantage. These factors increase the risk of child abuse and neglect and contribute to a level of vulnerability that negatively impact on individual and family health and wellbeing. *Healthcare that counts* has been developed to support health services to improve responses to this group of vulnerable families.

Healthcare that counts provides guidance to enable health services to embed organisational governance, systems and structures focused on vulnerable children and families. This framework builds on and replaces its predecessor, *Vulnerable babies, children and young people at risk of harm: Best practice framework for acute health services 2006,*[1] which has guided the responsiveness of Victorian hospitals. *Healthcare that counts* is broader in scope than the 2006 framework. It extends the approach to all parts of the health sector as disadvantaged Victorians access all parts of our health system, from community-based and primary health settings, to acute tertiary hospitals.

Healthcare that counts emphasises the health provider's role in **recognising** factors that contribute to risk and **intervening earlier** to reduce or prevent further harm. The framework also promotes **collaborative partnerships** across all sectors working with vulnerable children and families so that responsibility for ensuring children's safety and wellbeing is shared. For health services that work with adult clients, the framework highlights the need for **family-sensitive and inclusive practice** so that the needs of dependent children are visible and promoted.

The sustaining vision of *Healthcare that counts* is that all Victorian children benefit from health services that promote and protect the safety, health, and wellbeing of vulnerable children and families.

1   Department of Health and Human Services website: **https://www2.health.vic.gov.au/about/populations/ vulnerable-children**

How to use this framework

Healthcare that counts specifies action areas to guide health services and health professionals to identify and respond early to support vulnerable children and protect them from harm. The action areas provide key performance and quality indicators for health services that complement existing safety and quality requirements applicable to health services and community service organisations.[2] The action areas can also be used to align with any existing quality improvement and accreditation processes operating within each health service.

Examples of best practice case studies and resources are used throughout the framework and a self-assessment tool is available online to guide implementation. *Healthcare that counts* is supported by the Department of Health and Human Services' *Children at risk* website[3] and the *Children at risk* learning portal for health professionals.[4]

There are also a range of other resources within specific sectors that can support implementation and training. For example, in the adult mental health services the *COPMI* (Children of Parents with a Mental Illness) website[5] also provides a range of evidence-based e-learning modules and resources. The *Common risk assessment framework for family violence*[6] and the *Common approach*[7] for identifying early signs where a family needs support also provide valuable information that can be used within health services to build capacity and skills.

Health services can use the *Healthcare that counts* action areas to guide strategic planning, evaluate performance, identify gaps in practice and implement the actions required to improve care and outcomes for vulnerable children and families. In using and applying the framework, health services are encouraged to adopt a continuous quality improvement model.

Consider the following questions for each of the *Healthcare that counts* action areas:

- **Do we meet the indicators of best practice in this area?**
- **How do we identify, monitor and report our performance outcomes?**
- **What data do we collect in this area?**
- **What are the gaps we have identified?**
- **What specific actions will we take to improve the process and practice?**

2   National safety and quality health service standards: **http://www.safetyandquality.gov.au**
3   Department of Health and Human Services website:
     https://www2.health.vic.gov.au/about/populations/vulnerable-children
4   Children at risk learning portal: **http://vulnerablechildren.e3learning.com.au/**
5   Children of Parents with a Mental Illness: **http://www.copmi.net.au**
6   Common risk assessment framework for family violence (CRAF):
     http://www.dvrcv.org.au/training/family-violence-risk-assessment-craf
7   Australian Research Alliance for Children & Youth website:
     https://www.aracy.org.au/projects/the-common-approach/the-common-approach#Common

Who should use this framework?

Throughout *Healthcare that counts* the term 'health service' is used. The term 'health service' applies to all health and community service organisations funded to provide a range of health services and programs by the Department of Health and Human Services and includes:

- hospitals (admitted and non-admitted services)
- registered community health services
- alcohol and drug services
- mental health services, clinical and community mental health support
- dental services
- Aboriginal health services
- counselling, parenting and other support services
- public and preventative health services.

These services or programs can deliver healthcare through public hospital settings, community settings and in community service organisations. The intent of *Healthcare that counts* is to guide and strengthen organisational and system-wide approaches that enable services – regardless of the type of delivery model – to improve, sustain and monitor their responses to vulnerable children.

The framework can also be used to support and guide other health providers such as private hospitals, general practitioners, maternal child health nurses and private specialists.

Terminology

Health professional is used throughout the framework to refer to all clinicians and practitioners working in any health and community environment. It includes practitioners who are employed by health services and who are working in the field of medicine, nursing, midwifery, allied health, social work, counselling, teaching, health promotion, refugee settlement, community work, or another role that works directly with clients of the health service. In some health services volunteers also provide some of these roles and are included in this definition.

Child or children is used interchangeably throughout the framework for brevity. It refers to all babies, children and young people 0–18 years old, including babies yet to be born.

Client is used to describe both children and adult users of health services who may be described or referred to as consumers, clients, inpatients and outpatients.

Family is used to broadly refer to the client and those with a significant personal relationship to the client, including biological relatives, partners, children, parents, siblings and carers. It includes same-sex partners and families with LGBTI parent/s.

Roles and responsibilities

Identifying and responding to vulnerability is a **shared responsibility**. Along with families, community services and government, all parts of the health system have a role to play in ensuring health services are accessible, culturally aware and deliver safe, high-quality healthcare to those who are vulnerable.

Parents, carers and their families are responsible for caring and protecting their children. Sometimes their ability to provide this role is compromised by factors that contribute to risk and vulnerability, including family violence, drug and alcohol abuse, mental health problems, cognitive impairment, homelessness and illness. Where possible, parents, carers and families should be engaged in any decision making that affects a child's care.

Children should be involved and participate where possible in decisions that affect them. Under the *Mental Health Act 2014 (Vic),* children may also have a role as carers and a 'nominated person' for a parent who is receiving treatment.

Health professionals have a responsibility to maintain and enhance their individual competencies to enable them to recognise factors that contribute to vulnerability. Once vulnerability has been recognised, health professionals are in a position to identify risk of harm, and have a responsibility to intervene and respond early to reduce that risk, prevent harm and support the wellbeing of the child. Where there is a belief that child abuse or neglect exists, health professionals must report and refer according to organisational guidelines and legislative requirements.

Health executives, managers and boards are responsible for identifying need, developing strategies for engaging hard-to-reach groups, supporting and maintaining a competent workforce and for ensuring organisational and clinical governance systems, processes and protocols are in place that meet the needs of the vulnerable populations they serve. This includes the safety, health, wellbeing and cultural needs of children within their health service.

Protecting vulnerable babies, children and young people is everyone's business

What is vulnerability?

Many families experience vulnerability at some stage. Sometimes the safety and wellbeing of families and children may be threatened by individual, parental, family or social circumstances. In some cases, these circumstances or vulnerabilities will be time-limited. For others, vulnerability can be significant and long-lasting and can affect children into adulthood.

What is clear is that vulnerability is a multifaceted problem that may not be readily apparent on an initial presentation at a health service. Assessment of vulnerability therefore requires careful continuous gathering of information, including formal assessment, observation and discussion with the family and the child.

Information gained about factors associated with risk or vulnerability should be balanced with information regarding the family's capacity to cope with stressors or problems. Availability of extended family support, good relationships with friends or neighbours and factors promoting personal resilience need to be taken into account.

Available information should be analysed and interpreted on the basis of the professional's experience and knowledge, to inform their decisions about the family's need for additional help.

Assessment of vulnerability using tools and checklists may be useful in some circumstances, but there is no one assessment tool or checklist that will reliably identify all children at risk.[8]

Factors contributing to vulnerability

Reports to child protection indicate a range of factors that contribute to vulnerability within family relationships. Many of the reports to child protection will involve family violence, parental mental health and parental substance misuse. Other factors contributing to poor outcomes for children include poverty, low-quality housing, the education levels of parents and the parents' inability to engage in employment. When family violence is combined with other problems, such as drug and alcohol abuse and mental health concerns, children are at even greater risk of developing emotional, behavioural, health, social and educational problems.[9]

Health services must have a heightened awareness of the family circumstances of their adult clients and consider the impact of illness or risk factors on their client's children.

- according to Department of Health and Human Services data, family violence concerns are related to almost half of all placements of children in out-of-home care, almost half of child protection reports and 71 per cent of substantiations.
- family violence is now the most common presenting area of concern for services referring to family support services (Child FIRST).
- Taskforce 1000, a collaborative project between the Department of Health and Human Services and the Commission for Children and Young people, has found that the majority of Aboriginal children in out-of-home care experienced family violence, substance abuse and mental health problems within their family.
- the proportion of reports to child protection involving drugs and alcohol has increased steadily over the past four years.[10]

8   Department of Health, Social Services and Public Safety UK 2006, *Guidance and principles of practice for professional staff*, p. 15.
9   Roadmap for Reform: strong families, safe children. The next steps Victorian government April 2016 pgs. 3,4
10   Roadmap for Reform: strong families, safe children. The next steps Victorian government April 2016 pg. 3

Figure 1: Tiered classification of vulnerability and corresponding needs

	Classification	Required response
Families that are highly vulnerable, children subject to abuse or neglect (<1 per cent) 4000 familes (around 8700 children and young people) per annum	In this group children are suffering abuse and/or neglect and require urgent and in some cases long term intervention from Child Protection	*Children require protective intervention*
Families that are vulnerable, with children at risk of harm (1.5 per cent) 10 000 families per annum	In this group families are vulnerable, and this spills over into concern for the immediate risk to children. High risk of requiring intervention from Child Protection	*Risk of maltreatment requires further investigation*
Families that are vulnerable (8 per cent) 54 000 families	Families in this group are known to be vulnerable, with risk factors present. Early action required where children present	*Early intervention to address vulnerability, including referral to secondary and tertiary services where required*
Families that might become vulnerable, risk factors present (20 – 30 per cent) 130,000 to 195 000 families	Families in this group have known risk factors for vulnerability due to significant stress in their lives. Maltreatment or neglect more likely to emerge in this group than broader population	*Families should be supported to reduce vulnerability and prevent abuse and neglect. Optimise participation in universal services*

Children from all cultural and socioeconomic backgrounds may become vulnerable, which can lead to possible child abuse and neglect. However, evidence suggests that some groups are at a higher risk of vulnerability. This vulnerability can be exacerbated without early intervention and adequate supports.

Health services should be accessible and provide appropriate services to vulnerable population groups in their local area, particularly:

- Aboriginal children, who are underrepresented in universal services that promote healthy development, learning and wellbeing;
- children of parents with a disability or mental illness where the parent or carer is not adequately supported through either secondary, tertiary and informal support networks;
- families that have recently arrived in Australia, particularly refugee families who have experienced trauma and hardship.

Responsive universal services

The Victorian health system as a provider of universal services is in a unique position to identify and respond to vulnerability, and at a level that is in proportion to the likely risk for children and families. In addition to delivering universal healthcare to all families, health services also deliver targeted and tailored responses for specific populations. Consequently, health services are able to deliver a range of services that match the degree of complexity or diversity of families.

All health services should put in place targeted interventions for individual children and families where it is identified that parental capacity to care or protect is limited. This can be done either through direct service delivery, or via referral pathways and partnerships with other agencies.

Depending on the need of children and families, interventions for vulnerable children or families can be time-limited. Interventions can also be more intensive, or extend over a longer period if required. This is particularly the case for children and young people who have been removed from their parents' care and are in the statutory out-of-home care system.

A lifetime of vulnerability – Sherry's story

Sherry (not her real name) is the mother of a young child and has substance abuse issues. She lived in out-of-home care from the age of four, and has had hundreds of different support workers over the years.

Child Protection referred Sherry and her child to a community-based substance abuse family support service. The service offered Sherry a minimum of two years with them so that her support worker would not be 'just another worker' in the list of hundreds.

Sherry was difficult to engage. She was openly suicidal and struggled to prioritise her child's needs. She expressed suspicion and anger towards Child Protection due to her own out-of-home care experience.

For the first six weeks, Sherry came to the office almost every day. She made herself a coffee and sat in the car park with a staff member. She talked about her feelings, stresses and challenges, and her guilt about being unable to provide for her daughter. Sherry said that the only thing preventing her from taking her own life was the fear that her daughter would be placed in out-of-home care like she was.

Over the next two years, the service was in contact with Sherry and her child at least weekly. Visits took place at the family home, the service's offices, the local magistrate's court, Sherry's methadone provider's office, or a little local cafe where she was well known. There was very little 'traditional' alcohol and drug counselling, even though Sherry was honest about her heroin and prescription pill use. She had long periods of abstinence but lapses were often brought on by her poor relationship choices.

Sherry's drug use decreased significantly when she was linked with a local psychiatrist who prescribed medication to help her manage her anxiety and mood disorder. A plan was also established to address legal, financial and housing issues.

Sherry's support worker also helped explore recreation options for Sherry and her child. They were linked with a local domestic violence centre that worked with both family members individually to deal with past trauma, and facilitated attendance at a children's trauma art group.

Sherry is still in contact with the service, and there is an agreement that the service will be involved if any concerns are raised by Child Protection in future.

Source: Mackillop Family Services

Monitoring best practice under the framework

To support health services to deliver *Healthcare that counts*, a separate self-assessment tool (available online) has been developed. Health services should use this tool to annually assess and document their progress in implementing and embedding the framework into their organisational governance structure and service priorities. The Department of Health and Human Services will continue to promote and monitor this quality improvement process via the annual Victorian Health Policy and Funding Guidelines[11].

The actions in this framework won't duplicate or change expectations of healthcare and community organisations.

The intent of this framework is to complement and enhance existing standards, accreditation and performance processes used by services.

The aim is to see a greater focus on developing and embedding approaches that promote, protect and improve the safety and wellbeing of vulnerable children.

Health services are required to meet a range of standards and benchmarks for safety and quality through the various legislated, funding and accreditation processes applicable to their organisation. It is anticipated that *Healthcare that counts* self-assessment and improvement activities will align with and support many of these processes applicable to the organisation. If your health service already has quality improvement tools, the *Healthcare that counts* self-assessment tool can be adapted to suit your broader organisational requirements.

Improving best practice requires strong leadership and time to build and strengthen capacity within an organisation. The time taken to embed the *Healthcare that counts* best practice performance indicators may therefore vary between health services. However, it is expected that all health services will take steps to meet requirements under each of the five action areas. Each year, services will need to demonstrate activities under the best practice performance indicators by using the self assessment tool.

Figure 1 provides an overview of the *Healthcare that counts* vision, principles and action areas. The next part of the framework will outline each of the five key action areas, including a description of the action area. It also includes best practice indicators and guidance about how health services can build on existing organisational structures and processes to demonstrate best practice.

11   Victorian health policy and funding guidelines
        https://www2.health.vic.gov.au/about/policy-and-funding-guidelines

Figure 2: Overview of vision principles and action areas

Principles

Respond appropriately, effectively and in a timely way to reduce risk and support children and their families to achieve improved outcomes

Vision

That all Victorian children benefit from health services that promote and protect the safety, health and wellbeing of vulnerable children and families

Protect and promote the health, safety and wellbeing of all children

Recognise vulnerability and identify risk and harm to children early

Promote culturally competent and responsive healthcare

Work together with families, community services providers and the statutory system in the best interests of children

Action areas

Action area 1   High quality governance for vulnerable children and families
Action area 2   Access for vulnerable children and families
Action area 3   Family sensitive and inclusive practice
Action area 4   Working Together
Action area 5   Effective communication and information sharing

Indicators of best practice in this action area:

1.1 Articulate the vision and purpose of how the organisation will improve support for vulnerable children and families in its strategic plan.

1.2 Ensure strong strategic and cultural leadership from the board and executive is demonstrated through planning, decision making and workforce development which includes a focus on vulnerable children and families.

1.3 Implement organisational policies and procedures that focus on vulnerable children at risk of child abuse and neglect.

1.4 Embed risk management systems that support the vision and purpose relating to vulnerable children and families.

1.5 Meet compulsory child safe standards to demonstrate that there are systems in place to protect children from abuse within your organisation.

Action area 1: High quality governance for vulnerable children and families

Health services must have demonstrated leadership and systems in place to protect and promote the health, safety and wellbeing of children and families.

Health services must be able to identify and respond appropriately to degrees of vulnerability. This includes situations where early intervention can provide support in a short-term crisis for children at imminent risk of harm due to parental incapacity (either temporary or longstanding), or those children placed in statutory out-of-home care for whom ongoing care is required.

Primary health services, particularly community health services and general practitioners, are in a strong position to intervene early and offer ongoing, sustainable engagement with vulnerable families through providing a range of universal services and supports.

Health services are expected to take a holistic approach to identifying vulnerable children. This means that all adult-oriented services consider (as part of routine care) risk and protective factors for dependent children. In the same way, child-oriented services need to take into account the broader context of the family and parenting, and put in place appropriate parental supports where needed.

Effective governance and leadership is essential if health service organisations are to embed the process and practice of supporting practitioners to identify children at risk of harm and improve the safety and quality of care for vulnerable children and families.

It is critical that health service boards, executives, managers and their staff all understand their roles and responsibilities in ensuring that robust corporate and clinical governance arrangements and effective quality and safety systems are implemented, monitored and reviewed regularly.

Guiding best practice and performance in this action area

1.1 Health services must have a clear vision

Articulate a vision for the care that your organisation provides for vulnerable children and families. Staff will then clearly understand what they are aiming for, be able to set priorities and actions to achieve this and be able to monitor their progress.
For example:

'To identify all children who come in contact with our health service, to directly or indirectly care for those who are vulnerable or at risk of harm and to provide effective services and care to prevent harm and improve outcomes.'

This can be translated into the experience you want to create for consumers, for example:

'Our strategic goals for the care and services provided to each of our consumers/clients is that all vulnerable families who come in contact with our health service experience, safe, respectful, coordinated and integrated care that is family-sensitive and culturally appropriate.'

The health service executive, in conjunction with managers and frontline staff, use the vision and purpose to inform key strategic planning, systems and behaviours within the organisation.

1.2 Strong, strategic and cultural leadership

Building strong leadership requires the senior executive team to support organisational change and provide communication and best practice linkages both within and external to the organisation. In work undertaken by large and small acute health services under the previous framework, nominating a senior executive and clinical leader with portfolio responsibility for vulnerable children was shown to have positive benefits on improving practice. These roles were significantly enhanced if the nominated lead had responsibility for planning and decision making about systems and services and could focus on clinical practice and staff performance in relation to identifying and responding to vulnerable children and families.

Executive and clinical leaders should be familiar with the latest evidence and best practice relating to identifying and responding to vulnerable children and families. They should understand the complexity and challenges of delivering frontline care to children and parents in key areas such as alcohol and drug misuse, mental health services (adult and child and adolescent), maternity services, emergency departments and other primary and community-based services such as Aboriginal health, counselling and parenting services.

Nominated executive and clinical leads can also actively support staff development and education strategies to foster a greater understanding of the needs and complexities of vulnerable children and families. They can provide direction and leadership in relation to strategies and initiatives to improve care and services based on the *Healthcare that counts* action areas.

To appropriately support the work of providing strong leadership, a vulnerable children committee or working group can assist in informing and guiding improvement strategies for vulnerable children and families. Under the previous framework, many acute health services found establishing such a committee to be invaluable as a way of beginning the implementation process to deliver best practice outcomes for vulnerable children. Some key features of a successful committee include:

- representation from all relevant disciplines (medical, nursing, allied health) and services across the organisation to reflect the various entry points for vulnerable children and families;
- key stakeholders from outside the organisation are included to build coordinated support and shared responsibility for vulnerable children and families;
- being chaired by a senior executive and reporting to senior executive management or the board of the health service;
- where appropriate, forming part of an existing working group within the organisation or a board subcommittee;
- meeting regularly and at a minimum every six months, keeping a record of meetings including details of attendees, and decisions and actions arising, and making this available across the organisation;
- be a vehicle for regular reporting to the board and executive on progress against strategies and actions to improve the safety, responsiveness and effectiveness of services for vulnerable children and their families based on the five framework action areas.

1.3 Organisational policies and procedures

Policies and procedures are fundamental to good corporate and clinical governance in all health settings. To support best practice in the area of vulnerable children and families it is important that specific organisational policies and procedures are put in place to support an early identification and response to vulnerable children at risk of child abuse and neglect. These policies and procedures should:

- provide direction for identifying and responding to vulnerable children such as practice guidelines, care pathways, processes for reporting and referral to and collaboration with other agencies including any statutory authorities;
- be consistent with obligations under relevant legislation including the *Children, Youth and Families Act 2005 (Vic), the Child Wellbeing and Safety Act 2005 (Vic), the Crimes Amendment (Protection of Children) Act 2014 (Vic), the compulsory minimum child safe standards*[12] and any other relevant government policy frameworks or standards;
- ensure that all staff and volunteers who have contact with children are subject to safeguarding checks as required by legislation and any government standards and that these checks are documented in staff and volunteer records;
- be reviewed on a regular basis to ensure they reflect best practice and available evidence.

12 The Victorian Government amended *the Child Wellbeing and Safety Act 2005* to introduce compulsory minimum child safe standards: **http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/projects-and-initiatives/children,-youth-and-family-services/creating-child-safe-organisations**

The implementation plan for any organisational policies and procedures should also include induction for all staff on their responsibilities relating to identifying and responding to vulnerable children and families.

1.4 Quality and risk management systems

There are a number of actions your organisation can take to ensure your quality and management systems are robust:

- Consider the risk systems in operation within your health service and how these might support risk identification and actions for vulnerable children;
- Prepare a plan, signed off by executive, identifying strategies and actions to improve your organisation's performance relating to effective, safe, responsive and integrated services for vulnerable children and families;
- Ensure that risk identification and mitigation strategies are in place for services delivered by the health service alone, or in partnership with other service providers including the statutory child protection system;
- Use risk registers to record risks, establish risk thresholds and trigger reviews of risk mitigation strategies;
- Collect and analyse data to inform risk management, as well as service development and improvement. This should include information on: presentations; service usage; consumer/client experience; incidents and near misses; complaints; problems and opportunities; effectiveness of services; and outcomes related to vulnerable children across both adult and children's services;
- Regularly review and monitor the health service environment in line with the minimum child safe standards to ensure it is safe.

1.5 Compulsory child safe standards

On 1 January 2016 the Victorian Government introduced child safe standards[13] to improve the way that organisations providing services for children prevent and respond to child abuse that may occur within their services. The *Healthcare that counts* framework is consistent with and will support organisations in meeting their broader obligations towards protecting children including the child safe standards. These standards apply to all Victorian funded organisations working with children and include Victorian health services.

Health services should pay particular attention to developing processes for recruitment and for reviewing staff performance that include safeguarding checks and clear guidelines for behaviour that reflects child safety. Services should also have clear policies and protocols that guide any reporting and investigation of staff behaviour where child abuse is suspected by a staff member or volunteer.

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13   Child safe standards resources, Department of Health and Human Services website: **http://www.dhs.vic. gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/child-safe-standards-resources**

Good practice case study: Use of the CARM Plan to support communication about safety concerns for vulnerable children

The Client at Risk Management plan (CARM) is a communication plan that has been developed by The Northern Hospital to alert staff to any safety concerns about children. The CARM plan acts a central point for recording information that can be easily accessed by multidisciplinary team members, or when information needs to be provided to agencies such as Child Protection. It contains structured information including a risk assessment and a communication matrix. While CARM was designed in a hospital setting it is applicable to a broad range of healthcare environments.

A CARM plan should be completed by a nominated person (at The Northern Hospital this is a social worker) for any patient who is involved with Child Protection. The completed plan is disseminated to key staff including the executive team, patient advocates and the relevant nurse unit manager or head of department. Once a CARM plan has been developed, it forms part of a client's medical file.

Use of the CARM plan has facilitated improved communication between social workers, nurses, medical staff and the executive team. It is used by social workers as a handover tool for midweek and weekend staff, as well as between sites. Nursing staff also use the CARM plan to inform staff about upcoming and current patients with Child Protection involvement including what plans are in place for their admission and discharge.

CARM was developed in 2006 following a period where a number of significant security alerts involving vulnerable families occurred. Since CARM was implemented, security alerts relating to vulnerable families known to child protection have reduced dramatically at The Northern Hospital. Use of the CARM plan has enabled the hospital to plan a response for children at risk that is coordinated and keeps families, visitors and staff safe, and has helped to reduce staff anxiety.

What staff have said about CARM

All staff across the health service indicated that CARM had assisted them in managing high-risk and complex patients. Ninety-one per cent of respondents indicated that CARM helped to keep vulnerable children safe.

'The CARM plan does assist enormously in keeping vulnerable children safe: It documents which clinicians are involved with the family, often indicates well in advance of presentation that specific issues need to be addressed, and indicates what issues have been addressed and what issues are outstanding'.
– Director of Paediatrics

Source: The Northern Hospital

An example of a CARM plan is included in the resources section of the Children at Risk portal
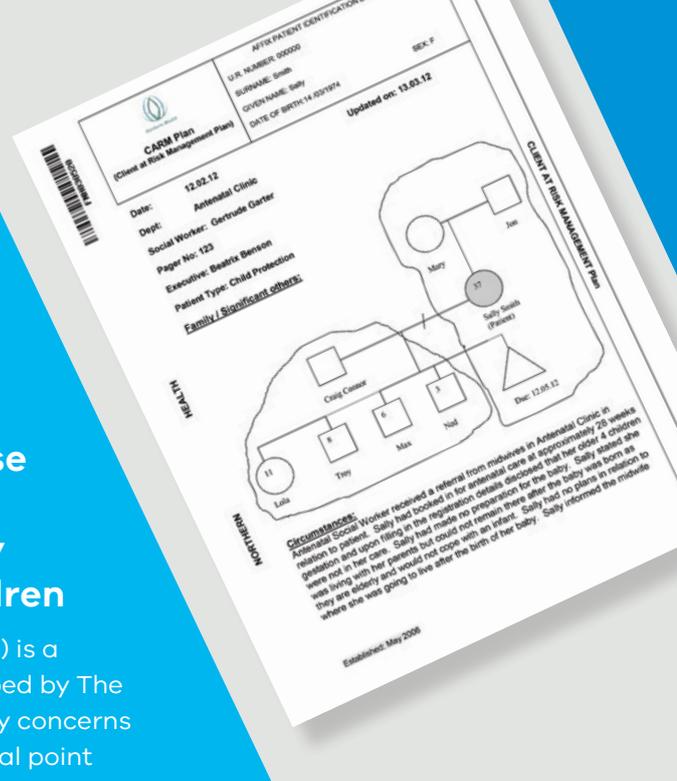
Indicators of best practice in this action area:

2.1 Identify and understand the needs of vulnerable population groups within the local area served by the organisation, and implement culturally appropriate strategies to address the needs of these groups.

2.2 Create a child safe, inclusive and welcoming environment.

2.3 Provide priority access and referral for high-risk vulnerable children.

Action area 2: Access for vulnerable children and families

Health services are accessible, flexible, inclusive, safe and responsive to the needs of vulnerable families.

Health services play a vital role in identifying and responding to vulnerability. It is therefore essential that access to health services for vulnerable families is easy, welcoming, safe and responsive to their needs.

Although most families in Victoria access services when and where they need them, others (often the more vulnerable) do not. Families and young people may make contact with services but then cease attendance, attend infrequently or not become fully engaged.[14] Failure to attend scheduled appointments (potentially placing the child or young person's welfare in jeopardy) can be an indicator of a family's or young person's vulnerability. It can equally be an indicator that services are difficult for families and young people to access or are perceived as inappropriate and need reviewing.[15]

Effective leadership to engage families and drive improvement requires commitment from health service boards, executives, management and all members of the health workforce. Tailored and targeted health service provision requires the implementation of flexible models that improve access and quality of care for vulnerable families. This involves reviewing communication processes with parents and carers, explaining relevant systems and processes during the delivery of care, supporting workforce development and performance, and ensuring robust lines of communication between primary and secondary health organisations.[16]

In developing inclusive environments, it is vital that health services seek out the advice and participation of Aboriginal and Torres Strait Islander, culturally and linguistically diverse, refugee and disability communities. Lesbian, Gay, Bisexual, Trans and Gender Diverse, and Intersex (LGBTI) populations should also be included in the development of inclusive and welcoming environments and the Rainbow eQuality Guide[17] provides a valuable resource to support this inclusion. By actively seeking the advice and ongoing participation of these diverse population groups, barriers to access can be reduced and inclusive, culturally safe and responsive environments can be created.

People accessing health services must be safe, and the onus is on health services to provide spaces for parents and children that are safe and welcoming. Health services should provide priority access for highly vulnerable and hard-to-reach groups and streamlined and coordinated referrals to specialist services when children and families require additional support.

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14   The Royal Children's Hospital Melbourne and Murdoch Children's Research Institute 2010, *Policy Brief: Engaging marginalised and vulnerable families*, no. 18.

15   *Powell C, Appleton JV 2012, 'Children and young people's missed health care appointments: Reconceptualising 'Did Not Attend' to 'Was Not Brought' – a review of the evidence for practice', Journal of Research in Nursing, vol. 17, no. 2, pp. 181–192.*

16   BASPCAN Child Abuse & Prevention, Child Abuse & Neglect website: **https://www.baspcan.org.uk/child-abuse-review/latest-research/**

17   Download further information from the Department of Health and Human Services website Rainbow eQuality Guide **https://www2.health.vic.gov.au/about/populations/lgbti-health/rainbow-equality**

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Accessible, safe and responsive services

2.1 Understanding and responding effectively to client needs by implementing organisational strategies

Collect and analyse demographic, public health and health service usage data to identify vulnerable population groups accessing the health service or living in the local area in order to better understand and respond to their needs.

Put in place structures and processes to enable consumers to participate in the design, development and evaluation of services. This could be through involvement in governance and committees or through specific initiatives to obtain information from vulnerable children and families about their experience of health services.[18]

Ensure that any strategies put in place are inclusive of diverse populations.

Examples include flexible hours of operation that suit parents, drop-in services, outreach and home-visiting options, appointment reminders that best suit parents and young people (phone, text message, social media) and embedding technologies within services including social media.

The Department of Health and Human Services has a range of consumer participation, equity of access and cultural diversity resources including *Doing it with us not for us,*[19] the *Cultural responsiveness framework: Guidelines for Victorian health services*[20] and *Delivering diversity – cultural diversity plan 2016–2019.*[21] Services should also aim to be responsive to issues related to sexual orientation, gender identity and intersex variations, and to understand the specific health and wellbeing needs of subgroups within the LGBTI population.[22] These policy frameworks, together with any existing diversity policies operating within the health service, can be used to inform access for diverse population groups.

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18 Are disadvantaged families 'hard to reach'? Engaging disadvantaged families in child and family services CAFA Practice Sheet, September 2010: **https://aifs.gov.au/cfca/publications/are-disadvantaged-families-hard-reach-engaging-disadva**

19 Download further information from the Department of Health and Human Services website: **https://www2.health.vic.gov.au/about/participation-and-communication**

20 Download further information from the Department of Health and Human Services website: **https://www2.health.vic.gov.au/about/populations/cald-health**

21 Download further information from the Department of Health and Human Services website: **https://www2.health.vic.gov.au/about/publications/policiesandguidelines/dhhs-delivering-for-diversity-cultural-diversity-plan-2016-19**

22 Download further information from the Department of Health and Human Services website **https://www2.health.vic.gov.au/about/populations/lgbti-health**

2.2 Creating a safe, inclusive and welcoming environment and reducing barriers

Information about the health service and its programs should be promoted locally in inclusive and culturally appropriate ways. Information should be translated into other languages known to be common in the local area.

Health services should actively work to build cultural safety within their organisation, through processes and staff competencies that reflect acknowledgment, acceptance and respect for diversity. For aboriginal families it is important that cultural responsiveness is demonstrated so that every "Aboriginal person, every Aboriginal child, feels that their sense of self and their identity is valued in some way by the people and environments that surround them."[23]

The principles underpinning the Victorian child safe standards, promote the cultural safety of aboriginal children, children from culturally and linguistically diverse backgrounds and the safety of children with a disability[24]. Embedding these principles into organisational systems are a vital part of creating safe and inclusive environments for vulnerable children.[25]

The health service physical environment should be welcoming, accepting and responsive to the needs of vulnerable children and families. e.g. comfortable waiting areas with baby change table in toilets or parents room, toys, games and magazines for different groups available. Administrative staff should be courteous and helpful to everyone, including family members.

Continuous feedback from clients is encouraged and should be used to develop health environments that are welcoming, inclusive and engaging for vulnerable groups.

23 Victorian Aboriginal Child Care Agency (VACCA), (2010), This is Forever Business – a framework for maintaining and restoring cultural safety in Aboriginal Victoria
24   Absolutely everyone State disability plan 2017 -2020 Download further information from the Victorian government website http://www.statedisabilityplan.vic.gov.au/
25 Download further information from the Commissioner for Children and Young People website http://www.ccyp.vic.gov.au/child-safe-standards/principles/index.htm

2.3 Providing priority access and referral for high-risk vulnerable children

Put in place organisational policies and strategies to ensure that children who have experienced child abuse and neglect and who are placed in the statutory out-of-home care system receive a priority service.[26] These children have poorer health outcomes and have complex care needs that require coordinated support and continuity of care.[27,28] For example, child health and adolescent health services should work with their local child welfare service to partition a small number of appointments specifically for children in out-of-home care.[29]

Establish and clearly document referral and reporting pathways for children at high risk of abuse. This will ensure responses can be put into effect without delay when it is identified that a child is at significant risk of harm. Supporting trauma-informed practice within the health service will greatly assist both referrals and services for highly vulnerable children in the statutory system.[30]

If non-accidental injury to children such as physical or sexual assault or serious neglect is suspected, it is vital that these children quickly receive a specialised, forensic paediatric assessment that can be used by statutory services. In Victoria the statewide Victorian Forensic Paediatric Medical Service (VFPMS)[31] is available 24/7 on referral only from a health professional, Child Protection or Victoria Police. VFPMS also provides a telephone consultation service to health professionals where there are concerns about possible non-accidental injury and abuse.

26 Community Health Integrated Guidelines priority access page: **https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines**

27 Royal Australasian College of Physicians 2006, Health of children in 'out-of-home' care, RACP, Sydney.

28 Department of Health 2011, *National clinical assessment framework for children and young people in out of home care*, Australian Government, Canberra.

29 Chief Psychiatrists Guideline 2011: **http://www.dhs.vic.gov.au/__data/assets/pdf_file/0009/661437/Chief-Psychiatrists-guideline-priority-access-for-out-of-home-care_WEB.pdf**

30 The Bouverie Centre website: **http://www.bouverie.org.au/support-for-services/our-specialist-areas/specialist-area-trauma-informed-practice**

31 Victorian Forensic Paediatric Medical Service (VFPMS): **http://www.rch.org.au/vfpms/**

Good practice case study: Improving service accessibility

Missed appointments – changing the focus from 'Do Not Attend' to 'Was Not Brought'

Vulnerable clients often miss appointments or disengage from services. This may occur for a range of reasons including: lack of child care; limited transport options; poor health; difficulty remembering or organising time; or because clients don't feel comfortable in the health service environment. Missing appointments can have serious consequences on the health of these clients and their children (including unborn children). It is important that health services have policies and processes in place to maintain contact with vulnerable clients and proactively support them to attend appointments. It is especially important to be vigilant in identifying and following up with families and carers when children are not brought to scheduled appointments because their non-attendance may indicate vulnerabilities in the family/carer environment.

A number of health services have triggers in their systems to instigate contact with clients. For example, if a client has missed two consecutive appointments, an appropriate health professional (such as a social worker or member of the specialist team working with the client) will then make contact by phone and/or in writing. This may involve a number of attempts. Once contact has been made, the health professional will explore any difficulties or concerns that may be preventing the client from attending appointments, and a response is put in place to support attendance in future. Responses may include providing taxi vouchers, arranging to bring children to the appointment, outreach visits, information about peer support and/or practical help such as financial advice. Information about the difficulties or concerns experienced by the client and the response provided should then be documented in the client's record.

Source: The Royal Women's Hospital, Monash Health and The Royal Victorian Eye and Ear Hospital

Good practice case study: Improving service access – the experience of East Gippsland

In East Gippsland, practical guidelines to improve service accessibility for families were developed in recognition that some families don't access services for a range of reasons, and it is often the way in which services are delivered that makes a difference to how accessible they are.

To label clients as 'hard to reach' puts the responsibility on clients, rather than the service. Services are funded to provide support and need to make sure they are accessible to families and children who need them the most.

An important component in developing the guidelines was to get feedback from families across East Gippsland about their experiences of accessing services for their families. Fifty-eight parents and carers (mothers, fathers, young parents, Aboriginal parents and parents with children with additional needs) provided feedback through interviews (via phone and in person), surveys and group focus groups.

The guidelines outline 11 principles and actions to improve service access:

- Meet parents' needs – be flexible to make the service easier to access and provide crisis support if needed, prior to any other service.
- Start where the family is at – identify and build on the strengths of the family.
- Every family is different –it is important to understand that families are diverse.
- Support to access – provide support for families to get to the service.
- Accessible locations and times –offer flexible hours of operation that suit parents, with flexibility around appointments and reminders that best suit parents.
- Coordination of services to meet family needs – develop agreed ways of working with other services to reduce the likelihood of families having to repeat their story.
- Availability and response – tackle waitlists or wait-times for services.
- Build relationships – take time to build quality relationships with families.
- Comfortable setting – ensure programs and activities are non-stigmatising and services are provided in a family-friendly and culturally inclusive environment.
- Engaging with the Aboriginal and Torres Strait Islander community – provide opportunities for staff to develop cultural competencies and to make connections with the community at the agency and program levels.
- Father-inclusive practice – recognise and acknowledge the important role of fathers in the community.

The guidelines include a self-assessment checklist designed to get agencies to reflect on current practice regarding service access. The checklist can be used to identify the areas organisations are committed to changing or improving and are mapped with a number of key quality frameworks to assist with quality assessment processes.

Source: East Gippsland Service Access Working Group. Membership of the working group included UnitingCare Gippsland, Communities for Children, Good Beginnings, Anglicare, Gippsland Lakes Community Health, Orbost Regional Health, The Smith Family and East Gippsland Primary Care Partnership.[32]

32   Visit the UnitingCare Gippsland website to download the guidelines for improving service accessibility: http://www.ucgipps.org.au/

Indicators of best practice in this action area:

3.1 Develop organisational values and guidelines that promote a culture of respect for children's rights and family diversity.

3.2 Build workforce knowledge and capacity to deliver effective family-sensitive practice at all levels of the health service from intake and reception through to ongoing care.

3.3 Implement care coordination and planning that considers the family and focuses on how the care and safety of children can be supported.

Action area 3: Family-sensitive and inclusive practice

Health services must uphold the rights of the child; consider the needs and interests of children when working with adults and promote family-sensitive practice.

Family-sensitive and inclusive practice supports the wellbeing of children by recognising the centrality of families in their lives. When working with families, health services must also respect and uphold the rights of the child to ensure that all decisions are made in the best interests of the child or young person.[33]

It is now recognised that an increased understanding and application of trauma-informed perspectives by practitioners and acknowledgment of the client's lived experiences can lead to more effective service responses.[34] Children can be highly vulnerable to experiencing trauma themselves when living with an adult affected by substance misuse or mental illness, or who is violent or experiencing violence.[35]

Family sensitive and inclusive practice, applies values, skills and behaviours that place family life at the centre of service planning and implementation.[36] A focus on family enables better identification of vulnerable children when parents are accessing adult-oriented services. Critically, family-sensitive and inclusive practice in all adult health services requires the identification of adults who are parents or carers and consideration of the needs of children as part of the everyday service engagement with clients. This is of particular importance where vulnerability is identified. Through acknowledging dependent children and intervening earlier, risk factors for vulnerability, and risks to health and safety of children, may be reduced.

Health professionals are encouraged to use approaches that expand the focus on child safety to include opportunities for early intervention and the promotion of child safety and development, with parents empowered to lead this process. By intervening at the earliest signs of vulnerability and by promoting positive parenting, parental capacity to provide a safe home environment can be strengthened.[37]

33 Children's Healthcare Australasia 2010, *Charter on the Rights of Children & Young People in Healthcare*: **https://children.wcha.asn.au/children-and-young-peoples-rights-healthcare-services-charter**
34 Centre for Disease Control and Prevention, Childhood Adverse Experiences (ACE) study: **http://www.cdc.gov/violenceprevention/acestudy/index.html**
35 The Bouverie Centre 2013, *Child Aware Approaches Project: Trauma informed family sensitive practice for adult oriented health services*, La Trobe University, Melbourne.
36 Department of Human Services and Department of Education and Early Childhood Development 2011, *Family-centred, child-focused support in the early childhood years: a guide for early childhood intervention service professionals*, State Government of Victoria, Melbourne.
37 Council of Australian Governments 2009, *Protecting children is everyone's business: National framework for protecting Australia's children 2009–2020*, COAG, Canberra.

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Family-sensitive and -inclusive practice

3.1   Promoting a culture of respect and inclusion

Promote a family-sensitive and inclusive culture within the organisation that sustains effective relationships between clients, family members, carers, practitioners and other staff members. Health services should create an environment that welcomes all family members including children, and encourages thoughtful responses for their care and wellbeing. Such a culture is promoted and supported through a welcoming physical environment, expressed values that are accepting and respectful of diversity, and systems and processes that enable family-sensitive care.

Australia is a signatory to the United Nations *Convention of the Rights of the Child*, and within Victorian health services it is important that the child's individual rights are upheld and promoted. Health services should consider the *Charter on the Rights of Children and Young People in Healthcare Services in Australia* (2010)[38] to support decision making based on the best interests of children and young people.[39]

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38 *Children's Healthcare Australasia 2010, Charter on the Rights of Children and Young People in Healthcare in Australia:*
    https://children.wcha.asn.au/children-and-young-peoples-rights-healthcare-services-charter
39 NSW Kids & Families Department multimedia resources demonstrating the rights of children and young people: **http://www.health.nsw.gov.au/kidsfamilies/programs/Pages/child-rights-video.aspx**

3.2 Strengthening workforce capability and capacity to deliver effective family-sensitive practice

Health services should be clear about the intent and scope of family-sensitive and inclusive practice. The purpose of involving families in the treatment and care of an individual is to achieve better outcomes for the client and family. In adult-focused health services the individual client remains the focus; however, there is an opportunity to engage with clients who are parents in a way that assists them to identify and address their own needs as well as their family's needs. This is particularly important in identifying and protecting vulnerable children.[40,41]

The implementation of family-sensitive and inclusive practice must occur at every level of the organisation. Intake and reception staff are usually the first interface for clients accessing a service.[42] Strengthening their capacity to identify parents with dependent children and to respond to the care needs of children may require specific training and support. Ensuring that routine registration/intake processes for all adult clients collect information about parental status, details of any dependent children and assesses the need for any referral and support will also assist.

It is important that evidence-based approaches to working with families are used within the health service and that these approaches are actively promoted by executive and management. Training for staff regarding family-sensitive and inclusive practice should also focus on the impact of trauma on individuals. This will provide staff with a better understanding of possible triggers experienced by trauma survivors and enables them to more effectively meet the needs of the vulnerable parents and children they are supporting.[43,44,45]

Trauma-informed models of care can be used in a range of health settings. These models are useful for identifying possible violence and abuse and providing strength-based interventions to support the safety and empowerment of children and family.[46]

Promoting resources and providing training for staff in developmental life stages of children is also valuable in supporting staff to develop evidence-based approaches in working with families.[47]

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40 See The Bouverie Centre website: http://www.bouverie.org.au/support-for-services/our-specialist-areas/specialist-area-trauma-informed-practice

41 Children of parents with a mental illness website provides resources for parents, children and professionals: http://www.copmi.net.au/

42 Department of Health and Human Services website: Alcohol and other drugs, intake and assessment guide, April 2015: https://www2.health.vic.gov.au/alcohol-and-drugs/aod-service-standards-guidelines/aod-program-guidelines/aod-intake-assessment-guidelines

43 Australian Childhood Foundation website: http://www.childhood.org.au/blog/home/2015/april/trauma-informed-care

44 Mental Health Coordinating Council NSW website: http://www.mhcc.org.au/sector-development/recovery-and-practice-approaches/trauma-informed-care-and-practice.aspx

45 Australian Institute of Family Studies, Child Family Community Australia 2016, *Trauma informed care in child/family welfare services*, CFCA paper, no. 37: https://aifs.gov.au/cfca/publications/trauma-informed-care-child-family-welfare-services

46 Clark C, Glasson C, Fourt A, Shetty M 2014, *Treating the trauma survivor: an essential guide to trauma informed care*, Taylor & Francis, New York.

47 Department of Health and Human Services website: http://www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families/child-protection/specialist-practice-resources-for-child-protection-workers/child-development-and-trauma-specialist-practice-resource

3.3 Family-sensitive and inclusive care coordination and planning

Health services must develop a comprehensive and documented care and discharge plan for parents and children where vulnerabilities are recognised. Good planning and care coordination is essential because it is unlikely that one service response will meet the diverse and changing needs of a family under strain.[48] For many vulnerable families, their ongoing needs can be overlooked as they transition from one service to another without any clear plan that documents their needs and the responsibility for ongoing support or follow-up.

Health services are responsible for coordinating or contributing to the coordination of a range of options for families. This may include varying forms of involvement, from short-term planning and problem solving to more specialist interventions.

Planning for vulnerable families can occur in a range of ways through partnering with other services within the organisation, partnering with external agencies or through active referral pathways with other agencies.

A care or discharge plan will consider the family environment and document any tasks or referrals for all members of the relevant family including any dependent children. Developing guidance and checklists for staff to support a family-sensitive and inclusive care planning and/or discharge process should form part of the organisation's regular training and performance monitoring.

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48 Australian Institute of Family Studies, Child Family Community Australia 2014, *The good practice guide to child aware approaches, Keeping children safe and well*, CFCA paper, no. 21.

Good practice case study: A parent with mental illness – the Ahmadi family's story

The Ahmadi family (not their real surname) of two parents and four children ranging from 12 months to 11 years old arrived as refugees from Afghanistan about two years ago. They soon came to the attention of mental health services via the settlement workers who were involved with the family.

The father was seeing an adult mental health community support service, which focused on his psychosocial needs. Family Services were also involved as there were concerns about the parents leaving the younger children with their 11-year-old daughter, which was their cultural expectation. The family support worker was important in explaining our child protection laws and ensured that an interpreter of their choice was present during these visits.

The family support worker also linked the family with the Families where a Parent has a Mental Illness (FaPMI) service. The children needed emotional support because they were worried about their father and witnessed the mental health workers in their home talking about medication.

The FaPMI worker who became involved with the family was able to help the parents explain to the children about what was happening with their father, who was diagnosed with schizophrenia and was leaving the household whenever he felt stressed. The children were seen over some time, so they were able to ask questions about their dad. As part of ongoing discussions using the resources provided by Children of Parents with a Mental Illness (COPMI),[49] they identified their uncle as an appropriate support person.

The family support worker was responsible for calling a number of case conferences, which were attended by the mental health service, the settlement worker and the FaPMI worker, who liaised with the clinical case manager to assist the family with some practical needs. For example, the children were sleeping on the floor and this was affecting their quality of sleep and how they felt at school, so beds and desks were organised for the family. Through FaPMI brokerage funding the family was able to participate in family-friendly activities such as going bowling and visiting an indoor play area (a suggestion from the children) so they could play indoors while their parents had a coffee in the centre nearby.

The family support worker helped the family set achievable goals, and the presence of the uncle was seen as a protective factor in the family.

The family no longer needs mental health clinical case management and no longer sees Family Services. The community mental health worker has stayed involved, and the dad's mental health medication is now managed by a GP.

Source: Monash Health

49   Children of Parents with a Mental Illness resources can be downloaded from: **http://www.copmi.net.au/kids-young-people**

Indicators of best practice in this action area:

4.1 Establish an active multidisciplinary committee that meets regularly to support intra- and inter-agency relationships and strategic planning for vulnerable children.

4.2 Develop strong organisational leadership that models collaborative practice and actively builds workforce capacity.

4.3 Establish agreed communication and referral policies/processes in relation to vulnerable children that are actively supported and reviewed regularly.

4.4 Implement multidisciplinary and multiagency case management and case conferencing for vulnerable children.

Action area 4: Working together

Health services and professionals must work together and with others to ensure care is effective, comprehensive and coordinated.

'*Assessment of the safety and wellbeing of children is not possible without services working together. Working together (through processes that enable information exchange, cooperation, collaboration and agreed approaches to cohesive service provision) is not an optional extra. It is not an enhancement to minimum requirements but is integral to good practice and service provision.*'[50]

Vulnerable children and families enter the health system at a range of different points (such as maternity services, drug and alcohol services, GP clinics and emergency departments) and require a range of health, human services and other professionals to be involved in their care. Providing multiagency support for issues of child vulnerability results in more effective interventions by delivering more effective assessments and coordinated responses.[51]

Collaboration is required through all phases of care from the initial assessment where the level of vulnerability and risk of harm is determined, to the delivery of interventions that are responsive to the client's needs and changing circumstances. In cases where transfer of care becomes necessary, actively managing the transition between health services or between the primary, secondary and tertiary sectors is important.

Working collaboratively across disciplines and sectors can sometimes be a challenging process, with potential for professional differences and structural barriers to create problems. Strong working relationships need to be established, where all parties respect the views of others, in order to provide a coordinated, multidisciplinary, multiagency response that builds the right services around the needs of the child. Robust structures also need to be put in place to help build and manage intra- and inter-agency relationships, and to improve outcomes for vulnerable children and families.

50   Victorian Child Death Review Committee 2013, *Annual report of inquiries into the deaths of children known to Child Protection,* Melbourne.
51   Smith JA, Efron D 2005, 'Early case conferences shorten length of stay in children admitted to hospital with suspected child abuse', *Journal of Paediatric Child Health*, vol. 41 (9–10), pp. 513–517.

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4.1 An active multidisciplinary committee that supports intra- and inter-agency relationships and strategic planning for vulnerable children

Multidisciplinary committees (such as the vulnerable children committee described in section 1.2) provide an important vehicle for building relationships between key stakeholders who work with vulnerable children and families. These committees can also be valuable in driving strategic planning within and between agencies to support collaborative practice.

4.2 Leadership that models collaborative practice and builds workforce capacity

Value-based leadership at all levels of the organisation is required to drive and embed a culture of improvement and accountability.

Executives and managers will demonstrate collaborative practice that promotes respectful, trusting and effective relationships across disciplines and sectors that focus on achieving the best outcomes for vulnerable children and families. This leadership includes being able to mediate potential issues and resolve situations where conflict arises.

Regular interagency meetings at an executive/management level will also support the development of collaborative practice. These discussions should include:

- each agency role and scope in responding to vulnerable children and families
- documenting policies and processes for sharing information
- opportunities for shared case management
- protocols for managing urgent issues
- processes for escalating concerns or complaints

Strengthening workforce capability and capacity to work effectively across disciplines and sectors requires professional development and training. In particular, training regarding the use of agreed policies and processes, as well as shared education with other sectors, enables a more profound understanding and respect for professionals' differing roles and responsibilities to develop.

4.3 Documented and agreed communication and referral policies and processes in relation to vulnerable children

Documented and agreed communication and referral policies and processes for vulnerable children that provide health service and external agency staff with a clear understanding of their respective roles and responsibilities are critical to support best practice and joined-up care.

These will include:

- policies that authorise collaboration at all levels within the health service, and are actively supported through communication and shared planning mechanisms;
- protocols that identify the triggers for a multidisciplinary and/or agency case conference in relation to vulnerable or at-risk children and families; define the roles and responsibilities; and document processes to be followed;
- policies and processes for managing vulnerable children in the case of transfer of care between health services or between primary, secondary and tertiary health sectors (an essential part of transfer arrangements is that the transferring agency ensures that all necessary information, particularly concerns about vulnerability and risk, are documented and formally handed over to the responsible agency);
- processes for escalating issues and concerns relating to vulnerable children and families, particularly if there is a serious and imminent risk to children;
- policies and processes for reporting and analysing incidents relating to vulnerable children and families, including where other agencies are involved.

4.4 Multidisciplinary/multiagency case management and case conferencing for vulnerable children

Multidisciplinary, multiagency work is strengthened by structured case management and case conferencing involving all the relevant professionals involved in a child's or parent's care. It is important that health services are proactive in initiating case conferences to discuss and allocate responsibility for meeting the needs of vulnerable children and families in their care. This enables all parties to share information about a child or family, combine expertise and undertake constructive discussions to support effective decision making.

Health professionals involved in multidisciplinary/multiagency case management should:

- understand their organisation's policies and processes regarding vulnerable children;
- be respectful and open to different views and areas of expertise both in their own fields and within external services such as Child Protection and Family Services;
- provide information about individual roles and the services they deliver (be clear about the boundaries and limitations of each service and where they need to refer);
- agree on action items or tasks, and document the responsibility and expectations for each of these;
- ensure that professionals working with the family agree to set tasks and timeframes (this should include arrangements for involving the family wherever possible);
- when there are concerns, particularly about children's safety, alert the appropriate manager immediately and continue to escalate until issues are resolved.

Good practice case study: Working together – a great news story

Jane is a 17-year-old Aboriginal mother to two-month-old Joel (not their real names). Jane grew up in the foster care system and has been in and out of school; she has often been associated with disengaged, disruptive peers. Jane struggles with mental health and emotional stability and she is a client of the Child and Youth Mental Health Service (CYMHS).

Jane has been receiving support from the Mallee District Aboriginal Services (MDAS) Early Years Service since midway through her pregnancy with Joel. Both health and case management arms of the service have wrapped around her to form a strong interpersonal relationship and voice for advocacy at her regular care team meetings. MDAS staff aimed to soothe anxieties for Jane, her unborn son and those responsible for her care by role-modelling attunement, developmental safety and confidence in local professional knowledge and resources.

This proved most beneficial when Joel was born and decisions about a parenting assessment in Melbourne were being made. Understandably, Child Protection wanted the best care for Jane and her son and, knowing about specialist live-in options in the city, discussed referral options. MDAS was able to advocate for intensive local support with regular observation, developmental assessment, sound engagement with Koorie maternal health services and assertive case management being available to ensure Jane and Joel's local success.

The care team and Jane agreed to trial supports locally, and regular transdisciplinary meetings were undertaken with all the key workers involved in Jane's care. As there were considerable concerns about Jane and Joel's safety, this required MDAS to proactively lead the discussion with professionals and provide updates on their progress. MDAS provided assertive outreach focused on bonding behaviours, cultural considerations and shared responsibility rather than blame and fear.

Jane was able to use her relationships with key professionals to engage local parenting supports offered via MDAS. She also shared reflective space with her MDAS team, identifying ghosts and angels in the nursery, difficulties in her past experience of being parented and how she is actively making different choices to ensure her own son does not miss out on love, care and having a regulated and attuned mum.

Jane is currently thriving with Joel. Her skills and bonding behaviours continue to improve. She is supported by a dedicated, transdisciplinary team and does not have to go out of her local area to prove her skills or willingness to learn. MDAS early years professionals ensure that bonding and attachment resources are plentiful and that communication is regularly shared across the care team. Co-case management between the accommodation provider, Child Protection and MDAS ensure that risks and strengths are identified and shared in collaborative ways.

Source: Mallee District Aboriginal Services

Good practice case study: Bendigo Health – a service response for women with complex pregnancy needs

Ellen (not her real name) was removed from her parents' care as a young adolescent due to neglect and physical abuse, and has had no contact with her parents for some years.

Ellen had her first child at 16 while still under Child Protection's care, and was supported by the Bendigo Complex Pregnancy Care program. The first few months went well, until Ellen's relationship with the baby's father broke down. She suffered a mental health issue and was admitted to a mother–baby unit for care. She absconded after a few days, leaving the baby behind, and Child Protection placed the baby into the care of its father and paternal family.

Ellen subsequently had a number of involuntary admissions to a psychiatric facility, and was diagnosed with bipolar disorder, post-traumatic stress disorder and postnatal depression. With medication and community support from psychiatric services, Ellen was able to live on her own in the Bendigo community. However, she had no contact with her baby.

Ellen met a new partner and became pregnant with her second child. When she failed to attend her first appointment at Bendigo Health, the maternity support worker (MSW), who knew Ellen from her previous pregnancy, contacted her and offered another appointment. Ellen responded well. She accepted a referral to the MSW and the Complex Pregnancy Care program, but failed to attend an appointment with the MSW. After follow-up phone calls, the MSW established that Ellen had memory difficulties, and began to text her a reminder prior to appointments.

Ellen and her new partner attended appointments together. They were keen to link with supports because they feared Child Protection intervention. The MSW confirmed that Child Protection already had an unborn report based on history, Ellen's current transience and her lack of stable accommodation. Ellen continued to receive support from community psychology services and was referred to a local youth housing support, who helped her and her partner secure more permanent accommodation prior to their baby's birth.

Ellen was very anxious about Child Protection involvement but accepted this was necessary because of her history. She attended a pre-birth case conference at Bendigo Health, which was also attended by a child protection worker, Ellen's psychology case worker, her housing youth support worker, her MSW and the local maternal and child health nurse. At the conference, Ellen and her partner were engaged in discussions about what support they would need, and agreed to recommendations to ensure their baby's safety.

When Ellen's baby's was born, Bendigo Health informed Child Protection, who then completed a postnatal assessment in the ward. A child protection order was then issued, allowing the baby to remain in Ellen and her partner's care with supports in place.

Ellen was discharged home with a healthy baby, and an agreed support plan. This included ongoing engagement with psychology services, maternal and child health home visits to assist with skill development and confidence, and youth support to maintain stable housing. Child Protection continued to assess and monitor Ellen's situation.

Ellen experienced no distress or panic post birth and remained grateful for the support provided by the Complex Pregnancy Care program. Twelve months later, Ellen and her partner are continuing to parent their baby with supports in place, and Ellen has commenced supervised access with her first-born child.

Source: Bendigo Health

Indicators of best practice in this action area:

5.1 Ratify policies, protocols and procedures that provide clear guidance regarding reports and referrals and the obligations and responsibilities to share information.

5.2 Educate health service staff about the requirements for information sharing in the best interests of children and the interface with health privacy and confidentiality.

5.3 Develop and implement local agreements in collaboration with local Child Protection services that include information sharing and the resolution and escalation of issues that may arise in managing or transferring information.

Action area 5: Effective communication and information sharing

Communication is open and transparent and information is shared between professionals and services in the best interests of the child.

The Victorian Child Death Review Committee has reinforced that failing to comprehensively share information is a systemic problem that must be addressed in order to improve responses to child vulnerability.[52] The review committee has also observed that the quality of information that is shared is critically important in providing the basis for a 'joined-up service response'.[53] Sharing information is a two-way process; information about the child's psychosocial needs and parental functioning can beneficially inform any ongoing health response and vice versa. Information sharing for vulnerable children should be viewed broadly in the context of what is in the 'child's best interest'.

Within a health service, senior executives and board members have a responsibility to ensure structured organisation-wide mechanisms are in place that promote open communication and information sharing in the interests of protecting and supporting vulnerable and at-risk children. Leaders within the organisation who actively endorse and model child safety as a priority will reinforce the importance of open communication.

Building relationships with local organisations facilitates communication and improves care coordination for vulnerable children. This involves regular ongoing liaison about information sharing between a health service, local Child Protection services, Victoria Police, community-based child and family services and other local services working with vulnerable and at-risk families. In cases where there is a breakdown in communication or a lack of action relating to shared information about risks to children, there should be protocols in place to escalate these concerns to senior management for action.

Health services need to ensure that all health professionals have a robust understanding of the information-sharing and consent processes that apply to vulnerable children within the child protection system governed by the *Children, Youth and Families Act 2005*. Barriers to sharing information can sometimes arise from misunderstanding that general privacy and health records legislation prevent the sharing of information to protect the safety of children when authorised under the specific *Children, Youth and Families Act 2005*. In cases where there is an immediate concern for a child's safety, health services should have processes in place to enable the urgent communication of information so that a response is not hampered by delays.[54]

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52 Victorian Child Death Review Committee 2013, *Annual report of inquiries into the deaths of children known to Child Protection,* Melbourne.

53 ibid., p. 42.

54 Victorian Department of Health and Human Services 2007, *Providing support to vulnerable children and their families: An information sharing guide for registered medical practitioners and nurses, and people in charge of relevant health services in Victoria*: **http://www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families/child-protection/child-protection-information-sharing-guidelines**

Guiding best practice and performance

Effective communication and information sharing

5.1 Ratify policies, protocols and procedures that provide clear guidance regarding reports and referrals and the obligations and responsibilities to share information

Health services should use policies and protocols to guide appropriate information sharing that reflects the best interests of the child. The purpose of communication and information sharing between health services and health professionals and other agencies (health or human services) is to enable timely, accurate assessment of risk and to put in place an appropriate response when there are concerns about abuse or neglect of a child. Health services require a thorough psychosocial history (including child protection concerns) to support their work with the child and family. It is therefore important that information sharing includes two-way communication.

While rights of patient privacy and confidentiality are always respected, these rights can be displaced when there are concerns raised about the safety of children and information is sought by child protection authorities to inform their risk assessment or ongoing case planning for the child. In cases where Child Protection requests this information under the *Children, Youth and Families Act,* information about the health service's involvement with a child or family may be provided without the consent of the parent or child.[55]

Information sharing for the safety of children also includes sharing information about adult clients to enable assessment and investigation regarding the capacity of the parents to safely care for the child.

Health service policies and protocols for vulnerable children referred to in action area 1.3 should include a section that outlines the legislated information sharing arrangements and the importance of sharing information in the best interests of children.

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55   See the Department of Health and Human Services website for guides on information sharing:
     http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/reports-publications/
     information-sharing-guide-quick-reference

5.2 Educate health service staff about the requirements of information sharing in the best interests of children and the interface with health privacy and confidentiality

It is important for health professionals to understand the impact that withholding information or not providing it in a meaningful way can have on the quality of decision making. A failure to create a complete picture that contextualises information and enables different perspectives and expertise to be shared and contribute to decision making may have serious consequences for a child and family.

It is not enough to simply have policies and processes in place. Health services, health professionals and Child Protection services must actively work on removing barriers to information exchange (such as misconceptions about legal constraints) and share information better to achieve optimal outcomes for children and families.

Education and professional development needs to promote a culture of collaboration and openness. Education about information sharing should assist health professionals to not only understand legal requirements and circumstances in which information can be shared but also assist in translating this into practice. This may include discussions about those factors that might impede information sharing such as workload; concerns about the level of information needed to make a report; perceived conflicts including maintaining engagement and effective therapeutic relationships with clients. These factors may be a particular concern for those working in adult services such as maternity, mental health, alcohol and drug services and emergency departments.

5.3 Develop and implement local agreements in collaboration with local child protection services that include information sharing and the resolution and escalation of issues

Coordinated responses from health, welfare, educational, law enforcement, legal and community services are essential to ensure the best outcomes for children and their families. Clear communication and well-functioning information-sharing systems support effective interagency cooperation and collaboration.

Research has shown that when information has not been shared it has often resulted in the non-confirmation of abuse or neglect, thereby denying children and their families protection from continued maltreatment.

Even more common than a failure to share information is the failure to assess the shared information accurately. 'Communication involves a complex interplay between information processing, interpersonal relating and interagency collaboration. The need to communicate purposefully and with meaning to relevant others must be borne by all practitioners at all times'.[56]

Developing systems and processes to share and assess information about the safety and wellbeing of children requires a commitment to working together across disciplines as described in action area 4. Building relationships and formalising case conferencing for vulnerable at-risk children should form part of any response where there is Child Protection involvement. Having an agreement or partnership with your local Child Protection service will ensure that case conferencing can take place with all the relevant professionals. An agreement or partnership will also assist in escalating issues to senior management in cases where information is not shared freely across sectors or participation in case conferences and shared decision making is not forthcoming.

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56 Reder and Duncan, Child Abuse Review Volume 12, Issue 2, pages 82-100 (2003) published online Wiley Interscience **http://onlinelibrary.wiley.com/doi/10.1002/car.787/abstract**

Good practice case study: SCAN – a case conferencing tool for reports to Child Protection

If a child is admitted to hospital and a report to Child Protection is made, a SCAN (Suspected Child Abuse and Neglect) meeting should be held and documented to share information and make plans for safe discharge. This should occur within 24 hours of admission or on the next business day.

The meeting process, as defined by the Royal Children's Hospital (RCH), outlines that the meeting should be convened by the nominated social worker for the case and chaired by the consultant under whom the patient is admitted. The meeting usually includes medical staff, nursing staff, a social worker, the Victorian Forensic Paediatric Medical Service (VFPMS), Child Protection (or Child FIRST), police and Gatehouse (for sexual assault cases only). The meetings can also be extended to include a community maternal child health nurse, a general practitioner and other relevant community service representatives (for example, from a disability, drug and alcohol or mental health service).

The key focus of the meeting is to:

- clarify the seriousness of the protective concerns
- share information and knowledge about the child and family
- determine whether the protective concerns will be managed by existing community supports or whether further investigation by Child Protection is required
- document any further actions and responsibility for these actions.

Formal minutes of the meeting including decisions and key tasks are documented by the RCH general medicine registrar and are provided to the meeting attendees within 24 hours. While this approach has a strong tertiary health approach, the concept of SCAN to share and assess information together in the best interests of children can be modified to suit community-based health services.

Source: The Royal Children's Hospital

Protecting vulnerable babies, children and young people is everyone's business

Good practice case study: Documenting of social interactions to better understand parenting capacity

The Documenting Social Interactions (DOSI) form was introduced to the women's and children's units at The Northern Hospital due to the difficulties experienced in sharing information about parents' interactions with their children, which is a key component in assessing the safety and wellbeing of children. The DOSI form provides health staff with prompts for recording information about a parent's social presentation and interactions with their child. The accompanying guide provides information about when it is appropriate to use the form and what kind of information to record. The information obtained using the tool assists in providing relevant, easily accessed information about parental strengths and weakness and is used to inform care, discharge planning, referral for support and Child Protection enquiries. The tool is particularly useful for sharing information with Child Protection and for reviewing the case history if evidence is required in any legal proceedings..

Using the DOSI form

A DOSI form is completed during each shift, even if the parents do not attend, as this then gives a comprehensive picture of a parent's contact with their child. The form is predominately completed by nursing staff and social workers; however, any health professional involved in the patient's care is encouraged to complete the form.

Use of the form can be triggered by a number of factors including: parents not visiting their child; concerns around attachment; parent's behaviour when caring for their child; when a baby is readmitted soon after discharge; when the DOSI form was used during the previous admission; current or possible Child Protection involvement; family violence issues; parents on methadone or Suboxone treatment; parents with a mental health diagnosis; or parents with a disability that is impacting on their parenting capacity.

Comments from practitioners about the DOSI form

This sheet clearly outlines the information vital for a thorough and appropriate assessment. It has also been very useful from a multidisciplinary point of view.
– Registered nurse, Children's Ward

The information about interactions with the child were very specific and detailed. I learnt about the parent's strengths, what practical skills they were good at, how they communicated with hospital staff and the amount of affection they showed their baby.
– Child Protection worker, NW Region

DOSI has improved my capacity to provide relevant information to Child Protection in a timely manner because it is well set out, easy to read and concise to present.
– Midwife, Maternity Ward

Outcomes

Using the DOSI form has resulted in a number of improvements including: an improved process for recording observations; improved communication between staff involved with the family; an increase in the number of appropriate referrals made to welfare agencies; an improved ability to highlight the strengths of parents, focusing on what they are doing well; and improved practitioner assessments and hence a decrease in Child Protection reports being made when a review of the notes suggests it is not required.

Source: The Northern Hospital

Appendix 1: Glossary of key terms

abuse, neglect	Generic terms used to describe an act or omission that endangers or impairs a child's physical or emotional health and development, including the misuse of power by adults over children. Although abuse is not an accident, neither is it always the intention of the person to inflict harm or injury.
belief	Legally, a belief is based on reasonable grounds as defined in s. 186 of the *Children, Youth and Families Act 2005*. The concept of 'forming a belief' is a thinking process where a person is more inclined to accept rather than reject that there is significant risk of harm for the child or young person.
carer	A person who, while not a parent of the baby, child or young person, has the daily care and control of the child. Carers may provide the care with or without fee or reward and can include relatives, friends or acquaintances of a parent, residential care workers, childcare workers, youth workers, nursing staff and foster parents.
Child FIRST	Child FIRST is a centralised intake service for all Family Services and is responsible for receiving referrals about a child/family where it is considered that the family is facing severe stressors that are impacting on the child's wellbeing and where there are concerns about the parent/carer's capacity to deal with those stressors.
Child Protection	The statutory service responsible for receiving reports and, where necessary, undertaking investigations of families in which children may be harmed (or be at risk of harm) and need protection.
child protection report	A report made to Child Protection under s. 183 (voluntary reports) or s. 184 (mandatory reports) of the *Children, Youth and Families Act 2005* based on the reporter's belief that a child is in need of protection.
child safe standards	Compulsory minimum child safe standards that apply to health services in Victoria as well as to other child-focused organisations that are funded by the Victorian Government.[57]
child wellbeing referral	A referral made to a child, family information, referral and support team (Child FIRST) under s. 31 of the *Children, Youth and Families Act 2005* based on the referrer's significant concern for a child's wellbeing.

57   Child Safe Standards, Department of Health & Human Services website **http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/child-safe-standards**

failure to disclose	A criminal offence under the *Crime Amendment (Protection of Children) Act Vic 2014* that imposes a clear legal duty upon all adults to report information about child sexual abuse to police.[55] Any adult who forms a reasonable belief that a sexual offence has been committed by an adult against a child under 16 has an obligation to report that information to police. Failure to disclose the information to police is a criminal offence.
failure to protect	A criminal offence under the *Crime Amendment (Protection of Children) Act Vic 2014* that imposes a clear legal duty upon people in positions of authority to protect children from sexual abuse. This duty applies to all those employed in relevant organisations including hospitals.
harm	The effect on a child from abusive acts by adults specified in s. 62 of the *Children, Youth and Families Act 2005*. (See also 'significant harm'.)
mandatory reporting	A report made under s. 184 of the *Children, Youth and Families Act 2005* to Child Protection by a mandated professional (police, doctor, nurse and others) that a child is in need of protection from sexual abuse or physical injury.
report	A report made to Child Protection by any person who believes on reasonable grounds that a child is in need of protection. Section 162 of the *Children, Youth and Families Act 2005* defines when a child is in need of protection.
out-of-home care	The term used to describe care for a baby, child or young person at a place other than their usual home and by a person who is not the child's parent. It can include staying with other family members or friends (kinship care), foster care, residential care, and other forms of independent care.
reasonable grounds	Defined in s. 186 of the *Children, Youth and Families Act 2005* as matters of which a person has become aware and any opinions based on those matters. A person has reasonable grounds to report when: • a child tells them they have been harmed • a child tells them that they know someone who has been harmed • someone else tells them, such as a relative, friend, acquaintance or sibling of the child, that they know or believe that a child has been harmed • observations of the child's behaviour or development leads them to believe that the child has been harmed • they observe physical signs of harm.

58 Department of Health & Human Services website **http://www.dhs.vic.gov.au/about-the-department/ documents-and-resources/policies,-guidelines-and-legislation/new-criminal-offences-to-improve-responses-to-child-sexual-abuse**

secondary and specialist services	Services that provide more intensive and targeted support where a problem has been identified, and offer programs that identify and reduce the personal and social stresses on parents that lead to family breakdown and/or child abuse. They include in-home family support, financial and family counselling, respite care, drug and alcohol services, health and mental health services, disability services and housing services.
significant harm	Harm to the child that is more than trivial or insignificant, but need not be as high as serious. Is important or of consequence to the child's development but need not have lasting or permanent effect, nor necessarily be treatable. (Justice O'Bryan, *Buckley vs CSV*, Supreme Court, Victoria, 1992)
universal services	Services that are offered to everyone. They include antenatal services, maternal and child health services, preschool and school education services, and general practitioners. Acute hospitals, while offering specialist care, also offer a universal service, particularly through their emergency departments.
Victorian Forensic Paediatric Medical Service (VFPMS)	A specialist statewide service for the forensic assessment of suspected child abuse and serious neglect. Provider partners include the Royal Children's Hospital, Monash Medical Centre and regional hospitals throughout Victoria.