Working together to prevent child abuse and neglect — a common approach for identifying and responding early to indicators of need

A report from ARACY on behalf of the Common Approach to Assessment, Referral and Support (CAARS) Taskforce to The Hon Jenny Macklin MP, Minister for Families, Housing, Community Services and Indigenous Affairs

A project under the National Framework for Protecting Australia’s Children 2009–2020
Working together to prevent child abuse and neglect – a common approach for identifying and responding early to indicators of need

Australian Research Alliance for Children and Youth
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The National Framework for Protecting Australia’s Children 2009–2020

Protecting Children is Everyone’s Business: the National Framework for Protection Australia’s Children 2009–2020 is a shared national agenda for change that promotes an integrated response to preventing child abuse and neglect in Australia. It was endorsed in April 2009 by the Council of Australian Governments (COAG) and all Australian Governments are committed to implementing the actions it contains.

More information on the National Framework is available on the website of the Department of Families, Housing, Community Services and Indigenous Affairs (www.fahcsia.gov.au).

The Australian Research Alliance for Children and Youth (ARACY)

ARACY is a national non-profit organisation working to improve the wellbeing of children and young people by advancing collaboration and evidence-based action for all Australia’s children and young people.

Despite Australia being a wealthy, developed country, crucial aspects of the health and wellbeing of our young people have been declining. ARACY was formed to progress evidence-based action to prevent the major problems affecting children and young people. ARACY tackles these complex issues through building collaborations with researchers, policy makers and practitioners from a broad range of disciplines.

To support the National Framework, ARACY has been working with the Australian Government to develop a common approach to assessment, referral and support (CAARS). ARACY co-convenes the CAARS Taskforce with The Hon Jenny Macklin MP, the Minister for Families, Housing, Community Services and Indigenous Affairs.

The Common Approach to Assessment, Referral and Support (CAARS) Taskforce

CAARS Taskforce comprises community leaders across government and non-government health, education and community sectors engaged in supporting children and families, with a particular emphasis on the prevention of abuse and neglect. A full list of Taskforce members can be found at Appendix A, Section A (page 57).
In specific terms the group came together to help develop:

- A consistent approach to identifying and responding early to the needs of vulnerable children and families; and
- Improved mechanisms for information sharing and facilitating pathways to appropriate supports and services.

Overall the role of the CAARS Taskforce was to:

- Decide on a process for the development of a national approach to the prevention of child abuse and neglect, supported by common assessment and referral;
- Guide the development of Common Approach components so that it is usable and adaptable within those services most likely to encounter first warning signs of risk of child abuse and neglect;
- Consider and recommend the resulting Common Approach and its components, and options for trialling the Common Approach in agreed sectors; and
- Agree on recommendations for future work.

Our partnership with the Allen Consulting Group

The Allen Consulting Group, one of Australia’s leading economic and public policy consulting firms, was commissioned by ARACY to develop a common assessment approach for use in services/disciplines that come into regular contact with children and families and are, therefore, most likely to encounter first warning signs of child abuse and neglect. The resulting approach was to fulfill a number of criteria and be supported by recommendations for improved information sharing and referral. The final report was also to include strategies for possible trialling in 2010–11 in order to test the usability, reliability and transferability of the approach in practice. That work, undertaken over a twelve-month period, provided the basis for an Interim Report presented to the CAARS Taskforce at the end of 2009 and available on the ARACY website, and subsequently, this final report.

The Allen Consulting Group

This project was funded by the Department of Families, Housing, Community Services and Indigenous Affairs under the National Framework for Protecting Australia’s Children 2009–2020.
Foreword

It is with great pleasure that ARACY, on behalf of the CAARS Taskforce, presents the final report of the Common Approach to Assessment, Referral and Support project to the Minister for Families, Housing, Community Services and Indigenous Affairs, the Hon Jenny Macklin MP.

The groundwork for CAARS was shaped by the ARACY publication *Inverting the Pyramid: Enhancing systems for protecting children*, which was launched by the Minister on 28 April 2009. That launch provided the occasion for the Minister's announcement of the CAARS Taskforce and the CAARS project, one of the first to commence under the COAG-endorsed *National Framework for Protecting Australia’s Children 2009–2020*.

The National Framework and the CAARS project share the vision of the safety and wellbeing of all Australian children, young people and families. The ‘Common Approach’ is designed for use by those practitioners whose day-to-day work brings them into contact with children and families – doctors, community health nurses, teachers, counsellors, child care workers and others. Able to be incorporated into existing workflow, the Common Approach aims to enhance practitioners’ capacity to identify and respond early to the needs of vulnerable children and families and provide them with the assistance they need before problems escalate into crises.

The CAARS Taskforce, co-convened by ARACY and the Minister for Families, Housing, Community Services and Indigenous Affairs, met four times throughout the life of the project. Taskforce members also participated in a Technical Working Group which met regularly by teleconference, and in consultations held in 2009 and 2010. Development of the Common Approach has been a highly consultative process, with 250 people participating in consultation workshops and subsequent ‘sounding out’ teleconferences, and many stakeholders contributing written feedback on the different stages of development.

The outcomes of the scoping stage of the project and recommendations for the subsequent development and refinement stage were presented in the Taskforce’s Interim Report, presented to the Minister in December 2009 and now available on the ARACY website.
The scoping, refinement and development stages of the project culminated in a detailed proposal for a Common Approach that includes a comprehensive Guidance Manual and reference to information sharing and referral processes. The detail of the Common Approach reflects the collaborative effort of members of the Taskforce and its Technical Working Group, and feedback and advice from extensive consultations with stakeholders including children and those practitioners most likely to use the Common Approach. ARACY’s facilitation of collaborative engagement with a diverse range of relevant partners has been critical for achieving a final ‘product’ that can be realistically used as an effective prevention tool.

At its last meeting on 17 June 2010 the Taskforce received and endorsed the final report of the project consultants and the recommended Common Approach and its accompanying Guidance Manual (see Sections A and B of this report).

The Taskforce affirmed:

• The **vision, aims and practice principles** of the Common Approach

• The **needs identification mechanism** and its focus on child wellbeing

• Professional guidance reference points and conversation prompts to guide the practitioner

• The **self-assessment questionnaire** to be used by (older) children

• The **collaborative process** that has informed development of the Common Approach over the past twelve months, with significant ‘buy-in’ from professionals, practitioners and other stakeholders across universal, targeted and statutory services in all jurisdictions
Final recommendations

The Taskforce also considered the consultant’s recommendations for moving from the Common Approach ‘blueprint’ that is presented here to an action plan for trialling and ultimately implementing the Common Approach. Final recommendations from the Taskforce build on those set out in Table 6.1 (Section A, page 56).

The CAARS Taskforce recommends that the Minister for Families, Housing, Community Services and Indigenous Affairs:

- Notes the significant progress in the development of a Common Approach to Assessment, Referral and Support (the Common Approach)
- Notes the CAARS Taskforce’s strong endorsement of further development and implementation of the Common Approach
- Considers mechanisms to support further development of the Common Approach, noting its potential relevance and application through the National Early Childhood Strategy and the National Framework for Protecting Australia’s Children
- Considers seeking the endorsement of COAG, through the Community Services and Disability Ministers Conference, for supporting the evaluation and implementation of the Common Approach by:
  - Expanding the Common Approach prototype endorsed by the CAARS Taskforce to include training material, online service database, website and documentation; and
  - ‘Live testing’ the CAARS prototype materials and common approach in at least three sites across Australia, firstly through formative evaluation and then through efficacy and effectiveness trials, before rolling out across Australia in a staged approach.
- Notes the advice from the CAARS Taskforce that additional funding is required to finalise prototype development and undertake live testing, and to progress organisational cultural change among universal and secondary services to support integration of the Common Approach into existing workflow.
- Notes that, subject to evaluation of the efficacy and effectiveness of the Common Approach, further funding will be required for national implementation to commence in 2013.
Conclusion

The Common Approach aims to progress shared responsibility across universal services for the safety and wellbeing of children, young people and their families. It has received support from those sectors most likely to use it – the health and teaching professions, counselling services, children and family services sectors, Centrelink and state and territory government departments.

This approach provides a very strong opportunity to significantly improve the wellbeing of children and reduce rates of child abuse and neglect. It is groundbreaking in its broad support base and unique in its approach. The Common Approach now needs to be taken to the next stage, which involves formative testing, efficacy and effectiveness evaluation, and perhaps most importantly, a program of cultural change to assist practitioners incorporate this preventive strengths based approach into everyday practice.

Professor Fiona Stanley AC
Chair, ARACY Board

Dr Lance Emerson
CEO, ARACY
Acknowledgements

ARACY wishes to acknowledge the encouragement, support and active participation of many individuals and organisations who have played a key role over the past twelve months:

- CAARS Taskforce members and their alternates, and members of the Technical Working Group (see Appendices A and B of Section A)

- Project consultants, the Allen Consulting Group

- CAARS Taskforce facilitator, Mr Michael White (MW Group Consulting)

- The 220 workshop participants (phase 1 consultations), five ‘user groups’ and eight young people (phase 2 consultations), and the individuals and organisations that submitted written feedback at different stages of the development of the Common Approach

- The NSW Commission for Children and Young People, for inviting and supporting young people to participate in consultations

- Staff at the Department of Families, Housing, Community Services and Indigenous Affairs

This document is presented in two stand-alone sections. Section A is the final report from the consultants, considered and affirmed by the CAARS Taskforce. Section B is the companion guidance manual to the ‘Common Approach’.
SECTION A:

Final report to the
Common Approach to Assessment,
Referral and Support (CAARS)
Taskforce and the
Australian Research Alliance
for Children and Youth (ARACY)
The Common Approach: A practical mechanism for identifying and responding early to indicators of need

June 2010
Final report to the Common Approach to Assessment, Referral and Support (CAARS) Taskforce and the Australian Research Alliance for Children and Youth (ARACY)
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The authors wish to acknowledge the Australian Research Alliance for Children and Youth (ARACY) and the members of both the Common Approach to Assessment and Referral (CAARS) Taskforce and the Technical and Information Sharing Working Group for their valuable input provided throughout the project.

The authors are also grateful to the many people from around Australia who provided valuable information and ideas throughout the consultation process, particularly to all stakeholders who attended the national workshops and the telephone conferences and/or provided written input.

We also gratefully acknowledge the support of the NSW Commission for Children and Young People for inviting and supporting eight young people to participate in the consultation.
Executive Summary

A new approach is needed for protecting Australia’s children

Current systems for protecting children in Australia are struggling to achieve their primary objective — to meet the needs of children. The statutory child protection system is overburdened with notifications of alleged child abuse and neglect, with numbers more than tripling nationally between 1999/2000 (107,134) and 2008/2009 (339,454) (AIHW 2008 and 2010). This represents huge demand on the resources within child protection agencies to assess and investigate these reports, and on government resources more broadly.

At the same time, it is recognised that the majority of parents and families have the capacity and the motivation to raise healthy and happy children. But for every parent and every family, raising children has its challenges, and everyone needs some help sometimes. This perception has led to the recognition that a new ‘early identification – early response’ approach is needed that provides children and families with the assistance they need before problems escalate into crises — without jeopardising a trusted relationship between the child/family and the professional who identifies needs and suggests a support pathway.

There is widespread consensus that the required shift towards prevention can be achieved through enabling universal service providers to take a more proactive role in promoting child wellbeing and responding early to signs of vulnerability than is currently the case. Service providers in the universal sector, who come into regular contact with children and families, are ideally placed to identify, at an early stage, that a child or family is in need of support, and to take action to provide that support or link that child and family with other relevant community support and universal and/or targeted services. Universal service providers targeted to use the approach recommended in this report include health professionals (doctors and community, child and maternal health nurses); teachers and school counsellors; childcare workers; Centrelink staff and others.

The CAARS Taskforce and what it is trying to achieve

The new approach is being developed under the auspices of the Common Approach to Assessment, Referral and Support (CAARS) Taskforce, which was established by the Australian Research Alliance for Children and Youth (ARACY) and the Minister for Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) in 2009. The CAARS project is one of the 12 National Priorities planned during the initial three year period of the COAG National Framework for Protecting Australia’s Children 2009-2020: Protecting Children is Everyone’s Business.

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1 In this report ‘child’ or ‘children’ covers all children and young people aged 0-18 years.
The Common Approach promotes the use of common language across professions and can be embedded in existing practice. With it universal service providers will have at their disposal a comprehensive and, at the same time, easy-to-use instrument that helps them identify the needs of children and families at an early stage. The Common Approach also provides guidance to practitioners on the next steps involved in assisting and empowering these children and families to meet their needs in an effective and timely manner. The Common Approach is thus expected to enhance the capacity of universal service providers to identify the strengths, concerns, protective factors and unmet needs of children, young people and families, and to facilitate a pathway to appropriate support services.

Ultimately, a consistent approach to responding early to need as a way of preventing an escalation of problems will contribute to the overall goal of enhancing the safety and wellbeing of Australia’s children.

**Pathway to a Common Approach**

The Common Approach and its components, as they are described in this report, have been developed in close cooperation with a large number and wide range of stakeholders over a twelve-month period. The project was carried out over two phases:

- Phase 1 — the *scoping phase* (July – December 2009), with an Interim Report as the major output. The Interim Report was presented to members of the CAARS Taskforce and the Minister for Families, Housing, Community Service and Indigenous Affairs. It identified viable components for a needs identification mechanism and key elements for optimal information sharing and referral, based on the findings from desktop review (i.e. a comprehensive review and analysis of relevant national and international literature on issues relevant to the development of the Common Approach) and stakeholder consultations (i.e. intensive, targeted consultations with over 220 stakeholders across all Australian jurisdictions and service sectors); and

- Phase 2 — the *refinement phase* (January – June 2010), with this report being the major output, presenting a blueprint for a Common Approach, including a mechanism for needs identification and guidance around information sharing and referral. The report also makes recommendations for how to move from this blueprint to nationwide implementation of the Common Approach. The blueprint presented here is the result of further intensive consultations with potential users and beneficiaries of the Common Approach — namely doctors, community and child and maternal health nurses, childcare workers, teachers and school counsellors, Centrelink staff and, importantly children — that served to fully develop and refine the approach and its components.

Throughout the project, valuable input was provided by members of the CAARS Taskforce and its Technical Working Group, and ARACY.

**What the Common Approach is — and what it isn’t**

The *vision* of the common approach, affirmed by The CAARS Taskforce Technical Working Group and the many practitioners consulted throughout phase 2, is to promote the safety and wellbeing of children, young people and families by identifying and responding early to indicators of need.
The Common Approach and its needs identification mechanism as presented here fulfills a number of criteria and characteristics considered important by the CAARS Taskforce and other stakeholders consulted. It is: child-centred; family-focused; universal services-focused; and provides a holistic response to child and family needs. In addition, the needs identification mechanism is simple, flexible, easy to use, adaptable to different contexts and well supported by those professionals who might use it in day-to-day practice. It has been designed with a view to promoting the use of common language to aid more effective communication across different service sectors and organisational cultural change.

It is important to note that the Common Approach and the needs identification mechanism developed as part of the Common Approach are in no way intended to replace an assessment of risks and, where it appears necessary and appropriate, reporting (including mandatory reporting) and referral to the statutory sector.

**The Common Approach and its components**

The Common Approach comprises the following components designed to aid needs identification, information sharing and referral:

- vision, aims and practice principles;
- needs identification mechanism; and
- guidance on information sharing and referral (see Figure below).
The components of the Common Approach are included in the accompanying Guidance Manual. This manual instructs universal service providers in the use of the Common Approach and should be read in conjunction with this report.

The vision, aims and principles express the concepts underlying the Common Approach and give universal service providers the context within which to identify and respond to need.

The ‘wheel’ is the central component of the needs identification mechanism and presents a holistic view of a child’s life. It is made up of six wellbeing domains (physical health, mental health and emotional wellbeing, safety, material wellbeing, learning and development, and relationships), thus providing a structure for universal service providers to think about different aspects of a child’s life, including those areas that are outside the practitioner’s immediate area(s) of professional expertise. Example issues have been identified for all domains across three ‘spheres’ — child, family and community. Strengths and needs can be found in each domain and each sphere.

The ‘wheel’ is complemented by:

• a professional judgement reference point, comprising high-level example indicators of need and questions for use by the practitioner before engaging with the child/young person or family;

• conversation prompts, designed to assist the practitioner to engage in a conversation with children, young people and families about their strengths and needs; and

• a self-assessment questionnaire, for use by children and young people (who can complete it themselves or assisted by an adult), which provides a range of answer options for each question and is designed to form the basis of discussion with a practitioner to clarify strengths and needs and explore any actions that could or should be taken.

The final component of the Common Approach is guidance for practitioners on moving from ‘identification’ to ‘response’ by tapping into relevant pathways of support and ensuring the right information is usefully – and respectfully – shared. This includes guidance on giving due regard given to potentially problematic issues of consent and confidentiality.

From conceptualisation to implementation: recommended next steps

To move from the ‘blueprint’ of the Common Approach to a national implementation strategy will require considerable groundwork, from securing the support of potential users to facilitating widespread organisational cultural change. A three-tiered approach is recommended:

• maintain the momentum achieved over the first year by actively engaging the universal services sector to promote and lead change;

• establish the effectiveness of the Common Approach; and

• establish the efficacy of the Common Approach.
These steps would occur concurrently with efforts to secure resources to support national implementation. In particular, a national online directory of universal, targeted and statutory services should be developed by the time the Common Approach is ready to be implemented at a national level. Other prerequisites for successful implementation of the Common Approach include targeted measures for education and training of users as well as a user-friendly website and other material related to the Common Approach and its mechanisms. Preliminary versions of these should be available for the testing stages so as to allow for refinement based on feedback from practitioners participating in the testing. The following table provides an overview of the recommendations for moving from the conceptual stage of the Common Approach to nationwide implementation.

The Common Approach is a practical step toward achieving the vision of ensuring the safety and wellbeing of all children, young people and families, well before early signs of vulnerability turn into crises.
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<th>Notional timeline</th>
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<td>Establish the steering group</td>
<td>Immediately (= project inception point)</td>
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<tr>
<td>Establish steering group</td>
<td>Steering group to select professional groups or organisations to ‘champion’ the Common Approach</td>
<td>Over the following 2 months</td>
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<tr>
<td>‘Champions’ to commence integrating the Common Approach in practice</td>
<td></td>
<td>Upon completion of selection process (within the next 2-3 months)</td>
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<tr>
<td>Resources allocated to professional sectors willing to promote cultural change</td>
<td></td>
<td>Ongoing</td>
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<tr>
<td>Select prototype testing sites through a competitive tender process</td>
<td></td>
<td>Within the first three months following inception</td>
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<tr>
<td>Establish coordinating mechanisms (e.g. determine Terms of Reference for coordinator role and steps for project management)</td>
<td></td>
<td>Within the first three months following inception</td>
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<tr>
<td>Commence 12-month prototype testing</td>
<td></td>
<td>Upon completion of competitive tender process</td>
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<td>Develop evaluation framework</td>
<td></td>
<td>Commence as soon as possible after inception</td>
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<tr>
<td>Conduct evaluation of the prototype testing</td>
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<td>Commence shortly after inception of prototype testing and finish 3 months post prototype testing</td>
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<tr>
<td>Determine appropriate rigorous research methodology</td>
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<td>Concurrent with prototype testing</td>
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<td>Undertake research to establish efficacy</td>
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<td>Commence in ca. 1 year</td>
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<td>Test the effectiveness of the Common Approach</td>
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<td>Establish the efficacy of the Common Approach</td>
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<td>Develop a national directory of services</td>
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<td>Stocktake of existing databases and services</td>
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<td>Commence immediately</td>
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<td>Commence immediately after selection of prototype testing sites</td>
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<td>Ongoing</td>
</tr>
<tr>
<td>Develop training material for prototype testing (e.g. prototype of guidance manual)</td>
<td></td>
<td>Over first 3-6 months</td>
</tr>
<tr>
<td>Refine existing material and develop additional training material and tools (e.g. DVD)</td>
<td></td>
<td>Alongside prototype testing (to be available at time of roll-out)</td>
</tr>
<tr>
<td>Explore opportunities for integrating training into existing professional education programs</td>
<td></td>
<td>Commence immediately</td>
</tr>
<tr>
<td>Prototypes of hard copy and online versions of Common Approach for prototype testing (e.g. wheel, conversation prompts, questionnaire etc.)</td>
<td></td>
<td>Over first 3-6 months after inception</td>
</tr>
<tr>
<td>Refine hard copy and website content and design</td>
<td></td>
<td>Alongside prototype testing evaluation (to be available at time of roll-out)</td>
</tr>
</tbody>
</table>
Chapter 1

The CAARS project

1.1 Why a different approach to protecting Australia's children is needed

Current systems for protecting children\(^2\) in Australia are struggling to achieve their primary objective — to meet the needs of all vulnerable children. The statutory child protection system is overburdened with notifications of alleged child abuse and neglect, with numbers more than tripling nationally between 1999/2000 (107,134) and 2008/2009 (339,454) (AIHW 2008 and 2010). This represents huge demand on the resources within child protection agencies to assess and investigate these reports, and on government resources more broadly.

The 2008 *Inverting the pyramid — Enhancing systems for protecting children* report (ARACY, 2009) revealed that current systems for protecting children resemble an inverted pyramid, or an hourglass shape (Figure 1.1). There is consensus by the Commonwealth, state and territory governments and community organisations in Australia of the need to reduce the burden on the statutory (tertiary) end of the system and to enhance universal (primary) and targeted (secondary) supports and services in line with the public health model. The three levels of prevention and intervention as defined by the public health model are:

- **universal (or primary) interventions** — strategies that target whole communities or all families in order to build public resources and attend to the social factors that contribute to child maltreatment (for example, those services provided by doctors, maternal and child health nurses, teachers, child care workers);
- **targeted (or secondary) interventions** — strategies that target vulnerable families or children and young people who are at risk of child maltreatment — that is, those with special needs who are in greater need of support (for example, those services providing drug and alcohol support, mental health services, homelessness/housing assistance, crisis care); and
- **statutory (or tertiary) interventions** — strategies that target families in which child maltreatment has already occurred, seeking to reduce the long-term implications of maltreatment and to prevent maltreatment recurring (including statutory care and protection services).

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\(^2\) In this report ‘child’ or ‘children’ covers all children and young people aged 0-18 years.
The public health model uses a pyramid to describe how systems should ideally be ‘weighted’ and provided for protecting children (see Figure 1.2). The large lower part of the pyramid represents primary (or universal) prevention strategies and services provided to all children and families, the middle part of the pyramid represents secondary (or targeted) prevention strategies for children and families who need more support than what the primary prevention strategies can offer them, and the smallest part at the top of the pyramid represents the tertiary prevention strategies which should be provided only to those few children and families who need intensive intervention.
There is widespread consensus that the best way to protect children is to prevent child abuse and neglect from happening in the first place by providing children and families with the assistance they need before problems escalate into crises. This can be achieved where universal service providers, who come into regular contact with children and families, are willing to take and share responsibility to promote child wellbeing and identify and respond early to the needs of children and families. The development of the Common Approach, which is aimed at enhancing the capacity of universal service providers to do so, is an important step in this direction.

### 1.2 The Common Approach — early identification and support for children and families in need

**A focus on prevention: the overarching goal of the Common Approach**

From the start of the project, the term *child protection* was intentionally not used, as it is often associated with policies and actions relating to interventions in the statutory sector. Rather, speaking of *protecting children* was found to be a more appropriate term to describe what this project is trying to achieve: it is not only the government’s business to reduce rates of child abuse and neglect but, in fact, everybody has a role to play in protecting children by promoting wellbeing and helping to prevent abuse and neglect where possible.

If Australia is to move to a more preventive focus for protecting children we need to move away from the context of ‘child protection’ which is seen as the domain of statutory authorities to a focus on ‘protecting children’ which is understood as being everyone’s responsibility. While the nomenclature is a small point, the implications are huge. Moving to prevention requires *all* systems that provide services to children and families to be part of the *collaborative system* for protecting children.

ARACY 2009, p. 15.
As an important step in this direction, this project aims to encourage and support professionals in the universal sector — such as health professionals (including doctors; community, child and maternal health nurses), teachers and school counsellors, childcare workers, and others — to make their contribution by providing them with the means to take appropriate action. The overarching goal of this project is to enhance the capacity of universal service providers to identify, at an early stage, that a child or family is in need of support, and take immediate action to link that child and/or family with relevant community support and universal and/or targeted services (see Figure 1.3). A corollary of this goal is that common language will assist communication and collaboration across universal and targeted services.

**Figure 1.3**

**THE COMMON APPROACH: A TARGETED APPROACH FROM A UNIVERSAL PLATFORM**

The Common Approach is built around an easy-to-use ‘needs identification mechanism’. Users of the Common Approach will be guided through a non-intimidating process that encourages discussion with children and/or family members about potentially complex and personal issues and leads to joint decision-making about support to meet identified needs. That support will build on existing strengths and protective factors and enable access to a support pathway, which may include universal and/or targeted services and broader community supports.

The Common Approach aims to normalise and strengthen this pathway, recognising that every person, every family has certain needs at different stages of their lives. Over time, extensive use of the Common Approach would result in a stronger, recognisable and effective culture of prevention and ultimately, measurable improvement in the wellbeing of Australia’s children and families.
**Needs identification versus risk assessment**

It is important to note that the Common Approach and the *needs* identification mechanism developed as part of the Common Approach are in no way intended to replace an assessment of *risks* and, where it appears necessary and appropriate, reporting and referral to the statutory sector. Existing legislative obligations for mandatory reporting will need to be fulfilled where it becomes clear that the identified ‘need’ is actually a case for referral to the statutory sector.

The Common Approach builds on the notion that providers in the universal sector are ideally placed to build trusting relationships with families and to work with them to seek appropriate support when the need arises. Identifying particular needs early and facilitating a link with appropriate support services should be seen as a normal process not associated with *risk* but instead associated with *need* — a far different context for both provider and family. Normalising the journey between universal and targeted services based on each family’s need is an essential part of a successful approach and cannot be over-stated.

**The Common Approach puts children and families in the driver’s seat**

In the Common Approach practitioners initiate and facilitate a conversation with the child or family aimed at identifying potential needs and referring them to appropriate support services, but what sets this approach apart is that the child and family are the ultimate decision-makers. They decide whether they want to have the ‘needs-identification conversation’ in the first place, and whether and in what kind of follow-up action they would like to engage.

The Common Approach has been designed to be as much an engagement mechanism as a needs identification mechanism. It will contribute to maintaining and improving the ways of engaging and communicating with families and, building and maintaining trust between the child or family and the professional.

### 1.3 Pathway to a Common Approach for protecting Australia’s children

**Project context**

In 2009, the Australian Research Alliance for Children and Youth (ARACY) and the Minister for Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) established a taskforce to drive the development of a *Common Approach to Assessment, Referral and Support (CAARS)* for vulnerable children and their families in Australia (see Appendix A for an overview of CAARS Taskforce members). This work follows on from the release of the *Inverting the pyramid — Enhancing systems for protecting children* report (ARACY 2008) and the *Protecting Children is Everyone’s Business: National Framework for Protecting Australia’s Children* 2009-2020 that was endorsed by the Council of Australian Governments in April 2009 (COAG 2009).
The National Framework for Protecting Australia’s Children promotes a long-term, integrated, national approach to promoting the safety and wellbeing of children. The Framework nominates six high-level ‘supporting outcomes’ and strategies for achieving them. Emphasis is placed on ensuring that all children and families have access to appropriate support and to services that help create the conditions for safety and care and that such support is ‘everyone’s business’, i.e. the protection of children is not simply a matter for the statutory child protection systems. The National Framework represents an unprecedented level of collaboration between the Commonwealth, state and territory governments and non-government organisations to protect children. The development of a Common Approach to identifying children and families in need and referring them onto adequate support services is one of 70 activities to be implemented as part of the first three-year action plan.

Project phases and process

The Common Approach and its components, as they are described in this report, have been developed in close cooperation with key stakeholders over a twelve-month period. The Allen Consulting Group was commissioned by ARACY for this work. The project was carried out over two phases:

- Phase 1 — the scoping phase (July – December 2009), with an Interim Report as the major output. The Interim Report was presented to members of the CAARS Taskforce and the Minister for Families, Housing, Community Service and Indigenous Affairs. Phase 1 included desktop research and stakeholder consultations leading to the identification of viable components for a needs identification mechanism and key elements for optimal information sharing and referral; and

- Phase 2 — the refinement phase (January – June 2010), with this report being the major output, presenting a comprehensive blueprint for a Common Approach, including a mechanism for needs identification and guidance around information sharing and referral. It also makes recommendations for how to move from this blueprint to nationwide implementation of the Common Approach.

Phase 1 commenced with comprehensive desktop research involving a review of both national and international literature on issues relevant to the development of a common approach. The review provided insight into relevant approaches in place in Australia and overseas, and informed the development of a Common Approach for Australia by revealing what works and what does not in terms of needs identification, information sharing and referral between the universal, targeted and other relevant support available in the wider community.
In recognition that Australian states and territories have considerable expertise in identifying and assessing children and families in need and referring them to appropriate support services, intensive targeted consultations were conducted with approximately 220 stakeholders over a four-week period from September to October 2009. During this time, 24 workshops were held — three in each of the eight Australian states and territories. In addition, the views of health professionals, such as general practitioners, paediatricians and nurses, were gathered by way of a telephone conference. Written submissions, received from a number of stakeholders who could not attend the workshops, served as further input into the development of the Common Approach.

Analysis of the literature review findings, feedback from the consultations and advice from the CAARS Taskforce has shaped the framework for the Common Approach. In line with this framework, Phase 1 of the project identified a pool of eight viable components for a needs identification mechanism, as well as mechanisms to improve information sharing and referrals to relevant support services and systems. A high-level risk analysis was applied to the eight components, and, based on the outcomes of this analysis, three options for a needs identification mechanism were recommended to the CAARS Taskforce. The Taskforce considered the suitability of these options and endorsed their further development during Phase 2, the refinement phase.

In order to fully develop and refine the Common Approach and its mechanisms during Phase 2, consultations were held by teleconference with five key user groups of the Common Approach, namely doctors, community and child and maternal health nurses, childcare workers, teachers and school counsellors, and Centrelink staff. Written submissions were also received from individuals and organisations in these sectors. In addition, a face-to-face consultation was held with young people to test the self-assessment questionnaire. Throughout the project, the Allen Consulting Group has worked closely and intensively with members of the Technical and Information Sharing Working Group (see Appendix B), members of the CAARS Taskforce and ARACY.

This report presents the result of this one-year process: a blueprint for a Common Approach, along with recommendations for testing the efficacy and effectiveness of the Approach and undertaking the groundwork for national implementation.

**Characteristics of the Common Approach and its mechanisms**

The CAARS Taskforce and other stakeholders consulted over the course of this project recommended that the needs identification mechanism fulfil a number of criteria and display certain characteristics.

Significant emphasis was placed on the needs identification mechanism being:

- *child-centred* — focusing on children and their needs;
- *family-focused* — helping to support and strengthen families;

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5 A full account of Phase 1 is included in the CAARS Interim Report, presented to the Hon. Jenny Macklin MP, Minister for Families, Housing, Community Services and Indigenous Affairs, in December 2009. The Report is available on the ARACY website: [www.aracy.org.au](http://www.aracy.org.au)
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universal services-focused — designed for use by universal service providers to identify families in need of additional support that could be received from either community, other universal or targeted services; and

a holistic response to child and family needs — taking into account both strengths and needs across different spheres and aspects of a child’s life; promoting collaboration between different services and sectors; and useful in identifying the next steps which should occur in relation to the child or family in need.

The CAARS Taskforce and other stakeholders further requested that the needs identification mechanism be simple, flexible, easy to use, adaptable to different contexts and well supported by those professionals who might use it in day-to-day practice.

In addition, it was considered that implementation of the Common Approach and its mechanisms should promote the use of common language to aid more effective communication across different service sectors and promote organisational cultural change. While actual culture change is not part of this project’s scope, it is acknowledged that a change to organisational culture would be an important prerequisite to the successful implementation of the Common Approach and its mechanisms, if it is to be accepted as ‘common’ within and across relevant services (see Box 1.1).

Box 1.1

ORGANISATIONAL CULTURAL CHANGE

For successful implementation of the Common Approach, particular issues regarding current system structures and functioning will need to be addressed, including:

• moving from ‘siloed’ services to a well integrated network of support across sectors;
• moving from a statutory child protection model to a public health model;
• moving from a compartmentalised approach to meeting needs to a holistic approach; and
• moving from individual practitioners not feeling able to take responsibility for preventive action to being empowered to do so.

Applying a Common Approach with a common purpose will provide the best outcome for children and so organisational culture must give ‘voice to the child’, focusing on the child’s experience from the child’s point of view. However, making this an integrated part of the workflow of relevant practitioners and their organisations will take time and require training to address barriers such as the perception of adding pressures to existing workloads.

In essence, bringing about cultural change will require:

• leadership and clarity about what culture to move away from and what culture to move to;
• active involvement of workers/professionals from the outset;
• provision of incentives to change;
• promotion of change in attitudes and norms with respect to children at the community level;
• incorporating change in funding agreements, service contracts and outcome reporting;
• an integrated approach across the three levels of government, non-government organisations and universal service providers; and
• training and promotion of best practice.

1.4 Structure of this report

This final report includes a description of the mechanisms developed over the course of the past year in consultation with a wide range of stakeholders. It is accompanied by a Guidance Manual to instruct universal service providers in the use of the Common Approach and should be read in conjunction with this manual.

After the introduction in Chapter 1, this document provides information around the components of the Common Approach:

- the vision, aims and practice principles;
- the needs identification mechanism; and
- guidance on information sharing and referral (see Figure 1.4).

Chapter 2 outlines the vision and aims of the Common Approach as well as practice principles that will guide practitioners in their endeavour to identify needs of children and families early.
Chapter 3 details the needs identification mechanism developed for use under the Common Approach, which draws on Bronfenbrenner’s ecological model of child development (Bronfenbrenner 1979). The needs identification mechanism is child-centred, family-focused, strengths-based, and it supports a holistic response to child and family needs. It is made up of six primary wellbeing domains (physical health, mental health and emotional wellbeing, safety, material wellbeing, learning and development, and relationships). Example issues have been identified for all domains across three ‘spheres’ — child, family and community.

The needs identification mechanism comprises four components that can be used together or individually. These four components are:

- The ‘wheel’ — which provides a structure for universal service providers to think about different aspects of a child or young person’s life, including those areas that are outside the practitioner’s immediate area(s) of professional expertise;

- A professional judgement reference point — which comprises high-level example indicators of need and questions for use by the practitioner before engaging with the child or family. The indicators and questions serve to validate an initial concern that a child, young person or family may have a critical need requiring further support;

- Conversation prompts — which assist the practitioner in engaging in a conversation with children, young people and families about their strengths and needs. The prompts are open ended, non-judgemental and linked to each indicator; and

- A self-assessment questionnaire — for use by children and young people who can complete it themselves or with an adult (a parent or practitioner). A range of answer options are provided for each question, which can help identify issues to be discussed with a practitioner to clarify the strengths and needs and explore any actions that could or should be taken.

The needs identification mechanism has been developed for use in paper and electronic form and can be administered by the practitioner with the child and family.

Chapter 4 addresses the process for responding to identified needs by linking the child or family with appropriate support. Issues relating to information sharing and referral are examined.

Chapter 5 provides an overview of the Phase 2 consultation findings.

Chapter 6 presents recommendations for how to move from this blueprint to nationwide implementation of the Common Approach.
Chapter 2
Vision, aims and principles of the Common Approach

This chapter introduces the vision and aims of the Common Approach, along with the practice principles and action statements on how the principles apply in practice. These make up the first component of the needs identification mechanism.

2.1 Vision and aims of the Common Approach

The vision and aims of the Common Approach are presented in Box 2.1.

Box 2.1
VISION AND AIMS OF THE COMMON APPROACH

<table>
<thead>
<tr>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promoting the safety and wellbeing of children, young people and families by identifying and responding early to indicators of need.</td>
</tr>
<tr>
<td>Aims</td>
</tr>
<tr>
<td>• To give universal service providers a way to identify and respond early to indicators of need that is simple, easy to use, flexible, evidence-based and adaptable for use in different services.</td>
</tr>
<tr>
<td>• To strengthen collaboration among service providers by promoting a common language and consistent approach to information sharing and referral within and between services.</td>
</tr>
<tr>
<td>• To facilitate a timely and child-and-family-friendly pathway of support for children, young people and their families.</td>
</tr>
</tbody>
</table>

Source: Allen Consulting Group.

2.2 Practice principles

Practice principles, as one component of the needs identification mechanism, were recommended in the Interim Report (Allen Consulting Group 2009) and supported by the CAARS Taskforce at its 30 November 2009 and 24 February 2010 meetings. The practice principles outlined here have been developed in line with the requirements set out in the Interim Report, which states that the principles developed and used under the Common Approach:

would be ‘practice principles’ referring to good practice in relation to listening to/working with children, supporting the role of parents, caregivers and families, taking responsibility for action as a service provider and acknowledging the broader role of the local community and other relevant services and supports. Practice principles would be educative, implementable and offer a foundation for the kinds of skills that are required for using the mechanism.

[...]
This component would provide the universal services sector with a set of principles to follow in their practice. The principles would provide guidance and consistency to service providers on a high level, while allowing localities flexibility to suit specific needs whilst remaining compliant with the overarching principles. Principles would reflect the child’s experience and viewpoint, service provider responsibilities and actions, the role of parents/care-givers and community responsibilities.

Allen Consulting Group (2009, pp. 96 and 76)

There are five core practice principles (see Box 2.2) for the Common Approach. Underpinning each principle are statements on what the principle means in practice for universal service providers (see Table 2.1). The principles and accompanying actions have been designed to be meaningful to universal services providers who are to use them as part of the needs identification process. Preference was given to using active rather than ‘bureaucratic’ language, as, written in active language, the principles were found to make a potentially greater impact on practitioners. They have been worded carefully with a view to challenging practitioners and boosting their confidence, but not being unduly confronting. For comparison an alternative expression of the principles written in passive language is included at Appendix C.

The concept underlying these principles is that identifying needs of, and supporting, children and families works best where the practitioner is supported by an organisational culture of shared responsibility, recognising that no single person can solve all problems on their own. It is, however, also recognised that the organisational culture may not always support the intentions reflected in these principles. In these cases, universal service providers are encouraged to reflect on their own ability to work within the system, and to draw on their own knowledge and capacity as they seek to respond to issues outside their usual area(s) of professional expertise.

Box 2.2

COMMON APPROACH PRACTICE PRINCIPLES

- The child and the child’s best interests are central
- An early response focuses on positive parenting and building on family strengths
- Shared responsibility and collaboration pave the way for effective support pathways
- Responding to early indicators of need is the best way to strengthen families and prevent crises
- The resulting pathway of support is free of stigma and fosters child and family involvement

Source: Allen Consulting Group.

A ‘child’ includes children and young people up to age 18.
## Table 2.1

### THE PRINCIPLES IN PRACTICE

<table>
<thead>
<tr>
<th>Principle</th>
<th>How the principles apply to you</th>
</tr>
</thead>
</table>
| **The child and the child’s best interests are central**                 | • listen to the child and involve them actively, and according to their ability, in all decisions affecting them.  
• treat all children, young people and their families with respect, regardless of age, presenting issues and cultural or social background.  
• be alert to the possibility of the child’s subjective experience of their wellbeing being different from that reported by their family.                                                                                                                                                               |
| **An early response focuses on positive parenting and building on family strengths** | • support parents to raise happy and healthy children, as this is the best way to ensure children’s and young people’s wellbeing and safety.  
• use a strengths-based approach that builds on and fosters existing capacities, competencies and social support networks, wherever possible.                                                                                                                                                          |
| **Shared responsibility and collaboration pave the way for effective support pathways** | • inform myself of relevant support services for children and families to expand my own knowledge and capacity to respond early.  
• take and share responsibility for the wellbeing of children by responding early and assisting a child and family in need to access relevant support services, even where this means taking action beyond my immediate, job-specific duties.  
• collaborate with families, other service providers and the local community to assist the child and family. By working in partnership we will facilitate more timely access to holistic care and can deliver a coordinated service response.  
• learn from the evidence of ‘what works’ and be open to creative solutions I have not previously considered — there is no single pathway to support.  |
| **Responding to early indicators of need is the best way to strengthen families and prevent crises** | • assist and support children and families as early as possible — before problems escalate.  
• promote children’s wellbeing and safety through referrals and resulting support pathways.  |
| **The resulting pathway of support is free of stigma and fosters child and family involvement** | • reassure children and families that everyone needs support from time to time.  
• involve children and families actively in all steps along the support pathway, from information and consent to decisions, referrals and follow-up.  |

Source: Allen Consulting Group.
Chapter 3

Approach to needs identification

The needs identification mechanism seeks to capture a holistic view of the child’s life, based on the ecological model of child development. The child sits at the centre of the framework, surrounded by their family (with a focus on the child’s parents or carers) and then the wider community (including friends, extended family and the family’s engagement with services such as pre-school or school and health services).

3.1 The ‘wheel’ — the central component of the needs identification mechanism

The ‘wheel’ presents a holistic view of a child’s life and is the central component of the needs identification mechanism (see Figure 3.1). It is designed as an aid to help universal service providers structure their thoughts about different aspects of a child’s life, including those areas that are outside their immediate area(s) of professional expertise. The wheel can also be used to guide a conversation with the child, young person or family member.

Wellbeing domains

The ‘wheel’ is made up of six wellbeing domains, which together capture a holistic view of a child’s wellbeing:

- physical health;
- mental health and emotional wellbeing;
- safety;
- material wellbeing;
- learning and development; and
- relationships.

These domains were identified from best practice models used in the context of child wellbeing and child protection and in collaboration with members of the CAARS Technical Working Group. A small number of broad domains have been selected for the Common Approach to ensure that the mechanism is relatively simple and flexible for practitioners in different universal services. Each domain captures distinct aspects of a child’s life.
Each wellbeing domain is clustered into three different ‘spheres’ in which strengths and needs can originate and occur: the child, the family, and the community (see Figure 3.1). The three concentric circles in the wheel represent these spheres — the child sits within the centre circle and is surrounded by their family and then the wider community, represented by the outermost circle. Within each domain, strengths or needs may lie exclusively with the child, or they may be related to the child’s family situation, including the capabilities of the child’s parent or carer, as well as the wider community within which the child lives, in particular the child’s and family’s social connections and networks in that community. This clustering is designed to assist the identification of needs and strengths and subsequent identification of appropriate support and associated referral process.

Figure 3.1

NEED DOMAINS APPLIED IN THE NEEDS IDENTIFICATION MECHANISMS

Source: Allen Consulting Group.
This approach draws on Bronfenbrenner’s ecological model of child development which acknowledges that a child affects, and is affected by, the settings in which he/she spends time (Bronfenbrenner 1979, Bronfenbrenner and Morris 1998). Similar models are used in existing child protection tools, such as Supporting Children and Responding to Families (SCARF) case management model used in New South Wales; the North Carolina Family Assessment Scale which has been adopted in the maternal health context in South Australia; Victoria’s Child Health and Wellbeing Outcomes Framework; and the UK’s Common Assessment Framework.

To provide a further visual aid to the universal practitioner, the wheel is populated with examples of relevant issues for each segment. These are generally positive and straightforward descriptions of broad areas of life where strengths and needs may lie, which can support a strengths-based conversation (see Figure 3.2). The use of the wheel as an aid to needs identification is explained in Chapter 4 of the guidance manual.

Figure 3.2
NEED IDENTIFICATION MECHANISM: ‘WHEEL’ AND EXAMPLE INDICATORS OF STRENGTHS AND NEEDS

Source: Allen Consulting Group.
**Recording strengths and needs using the wheel**

The universal service provider can use the wheel to record the strengths and needs identified, for example, by circling the segments of the wheel in which the needs lie in one colour and the strengths in another (or highlighting segments with a ‘click’ in an online version).

By following this approach, the practitioner will be presented with a picture of a child’s and family’s needs and strengths across the different domains. This will help the practitioner to identify in which area of a child’s or family’s life additional support may be needed as well as how to address needs by drawing on strengths and capabilities in the family or community sphere. This, in turn, will support practitioners in making appropriate referrals. Examples of how to use the wheel to record strengths and needs are provided in *Box 4.1 in Chapter 4 of the guidance manual*. Examples of how the wheel can support appropriate referral are provided in *Box 8.1 in Chapter 8 of the guidance manual*. The case studies in *Chapter 8 of the guidance manual* provide further direction on how to use the wheel in practice.

**3.2 Professional judgement reference point**

The professional judgement reference point provides practitioners with an **overarching question** for the practitioner to ask her/himself in relation to each wellbeing domain, to ‘test’ a concern regarding a child or parent, along with some **example indicators** and **supplementary questions** to help identify strengths and needs. The **questions** span across the whole domain, while the indicators broadly correspond to either the child, family or community sphere within that domain.

The professional judgement reference point is outlined in *Chapter 5 of the guidance manual*, with the indicators and questions in Table 5.1. An example of the overarching and supplementary questions for the physical health domain is given in Figure 3.3.
The example indicators are drawn from evidence on the factors associated with child wellbeing and future child protection concerns. The indicators cover similar issues to those within the ‘wheel’ but with more precision and/or detail regarding the specific need or strength that may be relevant. They are described using neutral language to support a strengths-based approach.

For each indicator there is a continuum from strength through to significant need. There are no distinctive ‘thresholds’ to suggest when the existence of a negative indicator implies a certain level of need that may require action, but in general, the greater the number of negatives, the higher the likelihood will be that underlying needs may require additional support. However, a negative indicator will not always indicate a need, for example, if the child/family is already receiving support with that issue or the child or family have strengths that mitigate the negativity.

Where an indicator of need seems to apply, or where the answer to one of the overarching or supplementary questions is ‘no’, the practitioner should take further action to identify underlying strengths and needs through discussion with the child, young person or family member and utilisation of the other components of the mechanism.
3.3 Conversation prompts

Where possible, when discussing issues with the child or family, practitioners will draw on their existing professional expertise and experience. However, as the discussions may need to touch on issues outside a practitioner’s area(s) of expertise or the practitioner is new to the profession, prompts have been developed to help guide the conversation.

The menu of these guiding prompts is presented in Table 6.1 in Chapter 6 of the guidance manual. These prompts are loosely linked to each indicator and each sphere (child/family/community). This allows the professional to select the appropriate prompts based on the domains in which a need may lie and the issues they are concerned about — in particular whether the issues focus on the parent/carer or on the child. An example of the prompts in the family sphere of the physical health domain is shown in Figure 3.4.

Figure 3.4
EXAMPLE OF CONVERSATION PROMPTS

These guiding prompts are intended to be open-ended so that they encourage a conversation, thereby allowing needs to be identified without the practitioner appearing judgemental or stigmatising. A range of issues is covered by the prompts, with the aim of revealing a range of possible needs. The practitioner can therefore choose from the menu as appropriate for the circumstances of each client — it is not anticipated that the practitioner would ask every question, although a selection (one or two for each domain) are recommended as ‘core’ prompts, which may provide a useful starting point for a discussion of each domain (see questions in bold in Table 6.1 in Chapter 6 of the guidance manual).

It is also noted that the direction of discussion flowing from the use of a prompt may be relevant to a different domain and/or sphere. For example, an open question about learning and development (Do you enjoy school?) could lead to answers suggesting needs or strengths regarding relationships (e.g. sense of belonging and friendships), or safety (e.g. bullying).
Chapter 5 of the guidance manual explains how the prompts should be used — including the importance of selecting and tailoring the questions according to the age of the child or young person and the cultural and language background and specific needs of the child, young person or family.

The prompts were selected after a review of existing professional guidance questions and surveys and evaluations of their effectiveness and appropriateness for identifying indicators of need in similar situations. They were subsequently amended and expanded based on feedback from the consultations and the Technical Working Group. Further detail on the evidence base and sources are provided in Box 3.1.

Box 3.1  
**KEY SOURCES FOR CONVERSATION PROMPTS**

- Victorian best interests case practice model, DHS Victoria 2008
- European Social Survey Questions and related guidance on measuring children’s wellbeing, New Economics Forum 2009a/b
- Patient-Health Questionnaire 2 (PHQ2)
- Short-form 12 (SF-12) and Short-form 36 (SF-36) health status questionnaires
- A Picture of Australia’s Children, Australian Institute of Health and Welfare 2009
- Doing Better for Children, OECD 2009
- Social, Emotional and Domestic Violence Screen Form, Northern Territory Department of Health and Families (DHF) 2009
- The State of Victoria’s Children, DEECD 2009
- The Structured Decision Making Model, Children’s Research Centre (CRC) 2008
- The Wellbeing of Young Australians, ARACY 2008

3.4  **Self-assessment questionnaire**

The self-assessment questionnaire is the component of the needs identification mechanism that has been designed for use by older children and adolescents. It complements the other components of the needs identification mechanism. The aim of the questionnaire is to:

- provide an opportunity for children/young people to identify their own strengths and needs; and
- provide another option to practitioners for engaging in conversation with young people.

Questions cover the six wellbeing domains and link to the indicators in the professional judgement reference point. The questionnaire takes between 5 and 10 minutes to complete and also includes a front-end introductory section with background information and guidance for completing the questionnaire.
Between three and five answer options are provided for each question. As such, it is relatively straightforward for a child to complete the questionnaire and identify areas of concern to share with the practitioner. Because of the scaled answers, the questionnaire also offers a continuum of possible responses for each issue. In addition, at the end of each section of the questionnaire there is a concluding question that provides children and young people with the opportunity to give that aspect of their life an overall rating on a scale. The self-assessment questionnaire is described in Chapter 7 of the guidance manual and located at Appendix A of the guidance manual, and feedback from adolescents consulted during the ‘sounding out’ stage, which was incorporated into the final version, is noted in Chapter 5 of this report.

The questionnaire is designed for children and young people aged 12 years and above, to complete themselves or with an adult (parent or practitioner). Access to the questionnaire is via one of two ways — either the practitioner can give the questionnaire to the child because he or she believes that it will assist to facilitate a conversation about needs, or the child may obtain the questionnaire from the internet or a public location such as a doctor’s waiting room. The pros and cons of individual access to the questionnaire are discussed in Chapter 5.

The guidance manual encourages practitioners to be flexible about using the questionnaire. They need to consider how comfortable children and family members feel about sharing their answers. Not everyone will want to share the completed questionnaire with the person who gave it to them or to the person they have chosen to have a conversation with. They need to be reassured that the decision to share the answers is theirs alone, and that decision will be respected. The questionnaire is a tool for stimulating discussion — it is not a result in itself.

**Interpreting the questionnaire**

While individual questions might result in answers that ring a ‘warning bell’ for the practitioner, one ‘negative’ answer in a domain does not necessarily indicate a need but will need to be considered in a broader context. The practitioner needs to look at each domain and weigh up answers in the light of other information, including known history of the child/family and observations such as body language and the way the child relates to others.

The information gathered from the questionnaire may be used to complete a ‘wheel’ by highlighting strengths and needs. This can be done with the child, as part of a conversation, or after a discussion. The resulting pattern should indicate the domain/s in which the child/family’s needs predominate, and will be a helpful pointer to the kind of support that may be needed.

As with other components of the needs identification mechanism, the questionnaire may lead to a child revealing issues in their life that are required to be reported to a statutory body. The section on ‘Expectations and obligations for practitioners’ in Chapter 7 of the guidance manual provides guidance to practitioners on alerting children to this possibility, and also reminds practitioners of their ethical and legal obligations in this regard. Chapter 9 of the guidance manual contains general guidance on how to explain to the child the possible implications of some of their answers when using any components of the needs identification mechanism.
Chapter 4
Information sharing and referral under the Common Approach

Identifying needs that, unless met, risk spiralling into crisis is one thing. Linking a child and his/her family with the kind of support that will make a real difference in that child’s life is quite another. The guidance manual includes a chapter (Chapter 8 Information sharing and referral) on moving from ‘identification’ to ‘response’ by tapping into relevant pathways of support and ensuring the right information is usefully – and respectfully – shared, with due regard given to potentially problematic issues of consent and confidentiality.

4.1 Introduction

The needs identification mechanism assists a practitioner to identify that a child or family has underlying needs that may require additional support. This is an important first step in promoting the wellbeing of children and families. Responding to these needs by connecting children and families to appropriate support is equally crucial to achieving the aims of the Common Approach — and this relies on effective processes and mechanisms for referral to appropriate services and supports and information sharing among relevant people who will provide that support.

The differences in referral processes, guidelines and practice across jurisdictions and professions, and in particular the different legislative provisions regarding information sharing, have presented challenges to developing an overarching national framework for information sharing and referral to support the Common Approach. The guidance manual sets out general guidelines on steps to be taken when critical needs have been identified and the child or family has agreed to seek some level of support. Possible referral pathways are noted and good practice for making referrals and sharing information is outlined. Key points about obtaining the informed consent of the child and/or family are summarised. The information in the guidance manual is designed to complement existing protocols and guidelines, direct practitioners to existing tools and encourage best practice approaches and greater collaboration between practitioners and across services.
4.2 Referral pathways and processes

Referral pathways

The emphasis in the Common Approach on early intervention and building on the strengths and capabilities of children and families means that the appropriate support pathway for a child or family may include informal supports (such as help from family members, if these relationships are identified as a strength) and/or one or more formal supports—including other universal services (e.g. health care, child care), community networks of support (e.g. church groups, parenting classes) and targeted services offering more specialised support (e.g. drug and alcohol support, mental health programs, financial counselling). The appropriate pathway to support should be identified in discussion with the child and family, to reflect their views and secure their agreement to the proposed approach.

Examples for practitioners on how to use the needs identification mechanism (the ‘wheel’) to identify support and referral pathways are provided in Box 8.1 in Chapter 8 of the guidance manual and in the case studies in Chapter 9.

Information on available support services

Practitioners may have, or seek, access to comprehensive information on available support services in the local area. There are various directories, databases and information services available, including directories and service listings that are specific to certain sectors or professions, such as the Australian General Practice Network, State and Territory Councils of Social Service, Family Relationships Services Australia and Centrelink. Listings of federal, state/territory and local government services are also available in regional ‘White Pages’ but are by no means exhaustive.

While these are valuable sources of information for specific sectors, for certain professional groups, or in certain geographical areas, they are not integrated and their currency, comprehensiveness and accessibility are not consistent. During consultations stakeholders identified the absence of easily accessible information as a barrier to connecting children and families to the appropriate services and making timely referrals.

A more consistent and comprehensive national approach to information and advice about relevant government and community services and their local availability would greatly enhance the capacity of practitioners to ensure children and families receive appropriate support when and where they need it. Recommendations for achieving this, including further detail on what will be required, are provided in Chapter 6.

Referral processes

To support a practitioner in making an effective referral, the guidance manual outlines key elements of optimal referral processes (in Box 8.2 in Chapter 8). These are:

- identify the appropriate service for the referral;
- put the child at the centre of the process;
- consider making a ‘warm’ or ‘friendly’ referral;
• share relevant information; and
• obtain feedback on the referral.

These key elements were developed based on the literature review and stakeholder consultation and feedback. The guidance manual provides an overview of what each of these elements involves and what that may mean in practice for universal service providers.

However, whilst individual practitioners can achieve some aspects of these elements, optimal referrals rely on an organisational and professional culture and local systems that support these approaches. In particular, different service providers and professions need to have a shared understanding of and commitment to the aims and principles of the Common Approach — including early intervention, collaboration and building on family strengths. This cannot be achieved solely through guidance to individual practitioners; it will require organisational cultural change, local interagency cooperation, awareness raising, and training in the Common Approach.

### 4.3 Information sharing

Sharing information between and within services, as appropriate, is integral to effective support pathways for children and their families. Information sharing is an essential element of collaboration among different service providers to provide holistic, coordinated and integrated support. Effective and respectful information sharing can also reduce the need for the child or family to relay the same information to different providers and ensure there is continuity in the support they receive.

Based on the literature review (in particular guidance on information sharing in relation to the UK’s Common Assessment Framework) and stakeholder consultations, four ‘golden rules’ for information sharing have been identified as crucial to supporting the Common Approach:

• open and honest communication with children, young people and families;
• informed consent from the child, young person or family member to share their personal information;
• necessary, proportionate, relevant, accurate, timely and secure information sharing; and
• concise record keeping.

The ‘golden rules’ are described in more detail Box 8.3 in Chapter 8 of the guidance manual. Ideally, practitioners would cross-reference the advice in the guidance manual with existing professional guidelines and protocols and/or legislative requirements for information sharing.
Obtaining informed consent

The guidance manual provides general guidelines to practitioners on obtaining informed consent from the child or family to share their information. It has been difficult to provide detailed guidance due to differing legislation and approaches to consent across jurisdictions, particularly with regard to obtaining the consent of children. For example, the age at which children are considered able to express their own views varies across jurisdictions and States and Territories have differing legislation about whether information given by a child would require a mandatory report. This influences how, and at what point, a practitioner may need to explain the implications of the information a child gives.

The key points regarding obtaining informed consent include ensuring that the practitioner explains clearly and precisely the purpose of the discussion, what information will be shared and the likely implications of sharing that information. As with the guidance on information sharing and referral, the emphasis is on a collaborative approach, which involves and engages children and families and ensures that the child’s best interests are central. Putting the child at the centre means seeking the consent of the child to share their personal information and agree to further support. Parental consent may also be required, depending on the age and capacity of the child as defined by legislation in each jurisdiction.

While the Common Approach focuses on prevention of abuse and neglect, it is acknowledged that there may be situations where ethical and legal thresholds are reached, i.e. a child is clearly at risk or has already been harmed, and a decision about sharing information with relevant authorities may need to be made without seeking the child’s or family’s consent. Such cases should be dealt with in accordance with existing guidelines, ethical codes and legislation relevant to the profession of the universal service provider and their jurisdiction.
Chapter 5
Summary of consultation findings

The development of the Common Approach and its components was informed by input from key stakeholders. Throughout the project, the Allen Consulting Group has worked closely with members of the Technical Working Group, members of the CAARS Taskforce and ARACY.

5.1 Brief overview of findings from Phase 1 consultations

During Phase 1 consultations were held with a wide range of stakeholders across the universal, targeted and statutory sectors (see Section 1.3 for more information). Overall, these stakeholders were generally very supportive of the Common Approach to identifying and supporting children and families in need. Stakeholders supported increased involvement of the universal sector and agreed there was a need to provide guidance to assist professionals in this sector to become more involved in assisting children and families early. The key findings from these consultations are summarised in Box 5.1.

Box 5.1
KEY FINDINGS FROM PHASE 1 CONSULTATIONS

Key findings from the consultation process are as follows:

- Stakeholders supported increased involvement of the universal sector and agreed that the Common Approach could assist professionals to become more involved and aware of the needs of children.
- Stakeholders agreed that early assistance would increase the likelihood that a crisis point would not be reached and decrease the likelihood that substantial intervention in the future would be needed.
- In terms of a needs identification mechanism, a key benefit would be the creation of a common language to aid more effective communication across sectors. A needs identification mechanism would need to be simple and adaptable to different contexts.
- Informed consent was mentioned as a key element for optimal information sharing as it is a prerequisite for maintaining trust, empowering families to take action and increasing the likelihood of family involvement. Guidelines, processes and protocols could be useful in promoting more effective information sharing.
- Optimal referral processes would involve ‘warm referrals’ and include feedback loops between organisations and back to the original referrer.
- Children and families need to have a clear understanding of the entire process and be involved in decision-making from the outset.
- Waiting lists and resource shortfalls were currently undermining referral processes.
- Implementation of a common approach would not only require a shift in organisational cultures but also a change in community norms.

5.2 Overview of Phase 2 consultation approach

Consultations during Phase 2 of the project sought to ‘sound out’ the proposed Common Approach and its components. Five groups of service providers, namely doctors; teachers and school counsellors; child care workers; community, child and maternal health nurses; and Centrelink staff were consulted to identify acceptance, ease of use and utility of the Common Approach and the guidance manual. These five groups were chosen because they represent the universal service providers most likely to come into regular contact with children and families and hence are key target groups for the Common Approach. User group participants included a sample of people who work directly with Indigenous communities, culturally diverse families or people with a disability. The consultations with user groups were held via teleconference. In addition, several individuals and groups submitted written feedback.

Consultations with the five user groups focused on:

- the overall vision, aims and high level practice principles of the ‘common approach’;
- the Needs Identification Mechanism which aims to assist professionals identify the strengths and needs in a child’s or young person’s life clarify or confirm matters that might require further attention or support;
- a self-assessment questionnaire that might be used as part of the needs identification process;
- processes and pathways for sharing information and facilitating referral and support; and
- the guidance manual – a reader-friendly and comprehensive guide to using the various components of the common approach.

A face-to-face consultation was also held with adolescents to check the relevance and perceptions of the self-assessment questionnaire as well as the ‘wheel’. This consultation focused on:

- the readability and user-friendliness of the self-assessment questionnaire and the ease with which it can be understood/answered;
- the usefulness of the questionnaire for helping children and young people to think/talk about issues in their lives;
- the value of using the wheel in discussion with young people; and
- other considerations such as access to support when sensitive issues are identified, and feeling comfortable about relating to professionals in the way described by the ‘common approach’.

Overall, the consultations were a rich source of suggestions, which were incorporated in the refinement of the guidance manual and needs identification mechanism. A summary of the feedback on each element of the Common Approach is provided at Appendix D.
**Broad support for the Common Approach and its components**

All the user groups expressed strong support for the vision and aims of the Common Approach and the themes and content of the principles. The guidance manual was found to be clear, comprehensive, well presented, practical and easy to follow. Many participants in consultations had no prior knowledge of the Common Approach and conveyed that they found it easy to read and comprehend. In particular, there was support for the strengths-based language and encouragement of the practitioner to be confident to think laterally and take responsibility for a holistic response to the child/family.

The needs identification mechanism was considered adaptable to different ages and stages of life and to cover both children and parents/carers. The feedback on the ‘wheel’ was overwhelmingly positive, with many consultation participants finding it a helpful visual and conceptual representation.

Particular concerns were raised regarding the self-assessment questionnaire and the guidance on information sharing and referral. The issues raised and the subsequent amendments made are outlined below. The other components of the Common Approach (the professional reference point and the conversation prompts) were generally supported, with some suggestions for specific wording changes that have been fed into the final product.

**Key findings regarding use of the Common Approach by different user groups**

Consultations with the five user groups indicated that in practice, the Common Approach and its components might be used in different ways. Similarly, different user groups might favour one or a combination of components, depending on the desired outcome of the discussion. The key advantages of the approach to each group and a summary of feedback that has now been incorporated into the guidance manual and/or final report are outlined below.

**Doctors**

The doctors found the wheel useful for capturing and conceptualising whole of life issues and felt that it reflected quality general practice. A key asset was its flexibility, allowing a dynamic representation of strengths and needs.

The guidance manual and its components were thought to be particularly useful as a teaching guide (especially in an electronic version) for young registrars and medical students as it would help them take a holistic view of health and wellbeing of children and families. It was also felt that the wheel was suitable for use in a busy general practice.

The guidance manual was affirmed as well written, especially with its strengths based approach. Some refinements were sought, including clarification of prompts for different developmental stages of a child’s life.

There was some concern about using the mechanism if necessary support services simply are not available and that expectations (of child/family) should not be raised if they cannot be met.
Child care workers
The Common Approach and its components were found to fit well with existing practice, tools and training for child care workers. In particular it was thought to be important that all child care employees were introduced to the principles of the Common Approach and how to use a ‘strengths-based’ approach in identifying and responding to need.

Explanation was sought as to what was meant by a ‘strengths-based’ approach; and it was also suggested that some of the prompts needed to start more gently.

Community, child and maternal health nurses
The nurses indicated that they already used a range of tools and prompts for in-depth engagement with children and families and that these will typically be more appropriate than the Common Approach for the client groups with whom they come into contact (in particular for infants and young children). However, they also regarded the guidance manual and components of the Common Approach as excellent for people new to working with children and families using a holistic approach and, consequently, that there was potential to build it into training.

Concern was expressed about the availability of support services, and the risk of raising expectations that they may not necessarily be able to meet.

Nurses noted that the prompts were best suited for use with older children, and wished to see better coverage of younger children’s developmental issues.

Teachers and school counsellors/psychologists
The teachers and school counsellors revealed that many teachers, particularly in high schools, may not see this as part of their role and would find it difficult to include the approach in their day-to-day workflow. However, they did observe that it was a useful conceptual tool and could be used to raise awareness among teachers and provide them with a conceptual framework. This would provide them with an opening for approaching other school personnel such as those with counselling, social work and pastoral care responsibilities, to alert them to their concerns. These personnel would then be better placed actually to implement the mechanism, including more detailed investigation of the issues with the child and parent or carer and considering extra help and referrals.

Overall, the guidance manual was seen as comprehensive, easy to understand, clearly expressed and user-friendly. The language was considered positive as it emphasised taking responsibility and encouraging collaboration with other personnel within the school and in external agencies.

Centrelink workers
Centrelink social workers are already familiar with a ‘holistic assessment’ approach to identifying needs. However, they saw the Common Approach as useful for grasping the broad concepts around wellbeing and needs and for normalising the need for help.

The wheel was also seen as a useful visual aid for engaging families, particularly for putting needs in a broader context and explaining why certain questions were asked and where they may lead.
There was also thought to be potential to link the Common Approach with existing workflows, including referral processes. Existing Centrelink service directories are very comprehensive and available nationwide, but may not capture all services that could help address the needs identified.

Consultation with adolescents

Adolescents found that the self-assessment questionnaire could be completed in a short time and was insightful. They considered it to be an ‘eye-opener’ that made them think about issues in their lives and consequently, which of these issues they would like to talk through with someone. They also observed that the questionnaire was less confronting and more intuitive than the ‘wheel’, which they did not find a helpful tool for identifying their own strengths and needs.

A number of suggestions were made for improvements to the design, format and wording of the questionnaire, which has been updated accordingly.

Key issues highlighted during the consultations

A number of suggestions were made during the consultations to improve and refine the components of the Common Approach and the guidance manual and many of these were accommodated. The major issues are outlined below along with an explanation of how these were reflected in the final product.

Need for a summary guide

Most user groups agreed that all the information in the guidance manual was necessary, particularly to allow for self-training. However the teachers and school counsellors advocated strongly for a summary document to give a conceptual overview of the approach. The child care workers also indicated that it would be helpful for the wheel to be presented at the front of the document. Accordingly, a summary guide has been developed which provides a brief overview of the Common Approach and its different components. This is presented at the front of the guidance manual.

Shorter and sharper principles

For the consultations with user groups, the content of the statements on what the principles mean in practice (Table 2.1) was presented as part of the principles. Several of the user groups observed that this list of principles was too long and wordy and the group of nurses proposed that the list be split into overarching principles and action statements to make the list more manageable, whilst keeping the detail and personalised focus of the actions. This proposal was accepted.

Tailoring to different age groups and for people from diverse backgrounds

The wording of the wheel, indicators and conversation prompts was found to be more suitable for older (i.e. school age) children and there was a view that there could be better coverage of issues for younger children. This included a proposal from the nurses to produce different versions of the mechanism for different age groups (perhaps children under five, children aged between five and twelve, and adolescents), which would allow greater tailoring to each group. Additional indicators and prompts have been added to better address the issues for younger children.
Further tailoring and/or adaptation (including a simplified and less ‘wordy’ version of the wheel) was also proposed by consultation participants who worked with Aboriginal and Torres Strait Islander and CALD groups and children and family members with disabilities and could be considered for the prototype testing stage. Suggestions for adapting the wheel included designing a pictorial representation of the segments, which are currently described with words and would not be helpful with children or adults with low levels of literacy. Similarly, the components of the Common Approach and indeed, the entire guidance manual, could be translated to various community languages.

**Use of the self-assessment questionnaire**

Several of the user groups expressed concerns in relation to how the self-assessment questionnaire might be used. In particular it was thought that it would be better to discuss these issues face-to-face rather than ask a child to complete the questionnaire on their own. Giving the questionnaire to a child to take away was considered risky in that there was a possibility the child would not return to discuss their answers with the practitioner. There was also a risk that the process of completing the questionnaire could make vulnerable young people feel worse about themselves if they did not have someone to talk to about their answers at the time.

As a result, most practitioners felt that the questionnaire should be used as part of a facilitated process.

However, the young people consulted took a different view. They said they would prefer to take the questionnaire home rather than complete it with the practitioner and that whilst they might not want to hand over a completed version to a practitioner, it was very valuable in helping them think about issues in their lives and which of these issues they might want to talk through with someone. This indicated that the self-assessment questionnaire is a very important component of the needs identification mechanism as it can empower children to identify their own strengths and weaknesses and take action, whereas all of the other components rely more on the actions of the universal service provider.

As a result of the feedback received the guidance manual has been revised to encourage practitioners to take a flexible approach. It is also recommended that the value of different approaches to using the questionnaire (as part of a facilitated conversation or for self-completion by a young person) be explored with both practitioners and young people during prototype testing.

**Linking information sharing and referral guidance to existing guidelines and protocols, including on informed consent**

Many consultation participants felt that more specific information was needed in the guidance manual about accessing local services and linking the referral processes and information sharing guidance in the manual to existing tools and guidelines. As a result some additional examples of sources of information regarding local services and referral processes have been incorporated into the guidance manual. These suggestions have also been built upon in the recommendations for prototype testing and trialling the Common Approach, as outlined in Chapter 6.
The guidance on informed consent was also a key issue in consultations. Each Australian jurisdiction has its own legislation and protocols and there is no standard age at which a young person is considered able to provide consent. It was suggested that the guidance manual provide access to information on state- or territory-specific protocol, in the form of links or some other form of template showing jurisdictional differences. The guidance manual has taken the approach of a high level outline of ‘golden rules’ for information sharing. Practitioners may also have access to guidelines and information specific to their profession or organisation.
Chapter 6

Recommendations for moving from blueprint to action

6.1 Rationale for recommendations

Overarching goals

The Common Approach is an important step towards enhancing the wellbeing of Australia’s children by identifying and responding to the needs of children, young people and families that, if not met, could escalate. It aims to enhance the capacity of universal service providers to identify the strengths, concerns, protective factors and unmet needs of children, young people and families, and to facilitate a pathway to appropriate support services.

Over the course of one year, a blueprint of the Common Approach, including its mechanisms for needs identification, information sharing and referral, has been developed in close cooperation with a wide range of stakeholders and experts in the field. The goal must now be to move from this conceptual stage to implementing the Common Approach nationwide, i.e. making it readily available to universal service providers and supporting them to respond effectively, holistically and early to children, young people and families.

From conceptualisation to implementation: overview of recommendations

To move from the ‘blueprint’ of the Common Approach to national implementation will require considerable groundwork, from securing the support of potential users to facilitating widespread organisational cultural change. A three-tiered approach, outlined in further detail in Section 6.3, is recommended:

• maintain the momentum achieved over the first year by actively engaging the universal services sector, including through ‘champions’, to promote and lead change;

• establish the effectiveness of the Common Approach; and

• establish the efficacy of the Common Approach.

These steps would occur concurrently with efforts to secure resources to support national implementation. In particular, a national online directory of universal, targeted and statutory services should be developed by the time the Common Approach is to be implemented at a national level. Other prerequisites for successful implementation of the Common Approach include targeted measures for education and training of users as well as a user-friendly website and other material related to the Common Approach and its mechanisms (see Figure 6.1). These are described in more detail in Section 6.4.
The steps toward implementation, and the process for a national rollout of the Common Approach, are dependent on a high level of funding support from Government.

The timelines envisaged for the realisation and implementation of the recommended steps in line with the three-tiered approach are outlined in Table 6.1 at the end of this chapter. Adherence to these timelines will be crucial for a successful nationwide implementation of the Common Approach.

### 6.2 Essential conditions of a successful Common Approach

Establishing stakeholder buy-in and promoting cultural change are essential conditions if the Common Approach is to be successful in achieving its vision and goals.

**Active engagement: establish and build stakeholder buy-in**

The vision and overarching goal of the Common Approach can only be achieved where the Common Approach is applied and used consistently by a critical mass of universal service providers across all states and territories of Australia. Initially, that would involve selected sectors, such as health, education, childcare and Centrelink, with the ultimate aim of rolling out to other sectors such as police and emergency services and other community services.

The Common Approach and its mechanisms for needs identification, information sharing and referral have been developed over the course of one year in consultation with a wide range of stakeholders. Stakeholders consulted include:

- members of the CAARS Taskforce;
- members of the Technical and Information Sharing Working Group;
• stakeholders from the universal, targeted and statutory sectors consulted during phase 1;
• five user groups consulted during phase 2 of the project: GPs, nurses, teachers, childcare workers, and Centrelink staff, including practitioners with a particular interest in potential application of the Approach to ATSI, CALD and disability population groups; and
• young people (aged 15-18).

Stakeholders gave valuable insights into the usefulness and likely acceptance of the Common Approach among universal service providers. The next step will be to test the Common Approach in the ‘real world’ before it is fully developed and implemented on a national scale (see Section 6.3).

Promote cultural change

One of the major challenges for the successful implementation of the Common Approach is the need for a cultural shift from ‘protecting children’ to ‘promoting child wellbeing’ and from ‘fragmented’ to ‘collaborative’ service delivery. A preventive culture will focus on supporting the wellbeing of the child and building on existing strengths and protective factors. It will encourage shared responsibility, including joint decision-making with the child and family and collaboration between service providers, families and communities. It will enable practitioners to take a holistic view of meeting a child or family’s needs and be supported by their organisations to do so.

Organisational culture is formed over years of interaction among all participants in the organisation or system. Cultural change often relies on key individuals within services to promote the change and provide strong leadership as they introduce and support new approaches among staff and colleagues. This process can be supported and promoted both within and between organisations. For example, organisations can encourage and motivate individuals to work collaboratively by:

• including the promotion/management of cultural change as a specific responsibility in job descriptions and/or key performance indicators;
• establishing collaborative processes and governance arrangements (e.g. memoranda of understanding) to ensure consistency in the way the Common Approach is communicated, introduced and implemented within and across organisations and sectors;
• building ‘Common Approach’ education, training and peer support into existing professional development modules and strategies; and
• communicating the vision and aims of the Common Approach regularly and often through existing intra- and inter-agency communication vehicles.

The shift of focus from protecting children to promoting child wellbeing and the culture of shared responsibility that underpins the Common Approach may also be championed by key leaders in relevant sectors, disciplines and agencies. CAARS Taskforce members themselves are in a strong position to promote organisational cultural change and support collaboration by influencing their own networks, organisational members and constituents. Section 6.3 provides further detail.
6.3 Three-tiered approach: essential steps towards successful implementation of the Common Approach

To successfully accomplish the transition from the blueprint presented in this report to nationwide implementation of the Common Approach, three steps are recommended. In the first instance, it is important to continue the momentum that has begun with the CAARS Taskforce over the past year. Additionally, in order to manage implementation at a national level, the Common Approach must be properly tested to assure effectiveness and efficacy. These ‘pre-implementation steps’ will reveal what works and what doesn’t in practice thus supporting the decision-making process regarding a nationwide roll-out.

In order to establish effectiveness and efficacy of the Common Approach, certain elements will need to be in place to support this testing — for example in order to assess objectively whether the Common Approach is effective and efficient in referring children and families on to adequate support services, a preliminary directory of services that includes the services in the area(s) in which the Common Approach is tested, will need to be available to participating service providers. Training material and, at a minimum, hard copy versions of the wheel, conversation prompts, the questionnaire and other material related to the components of the Common Approach will also need to be available. While preliminary versions of these might suffice for the testing stage, full-fledged material should be made available once the measures for establishing effectiveness and efficacy have been completed. They are prerequisites for a successful nationwide implementation of the Common Approach and discussed in more detail in Section 6.4).

Continuing the momentum – leading by example

It is recommended that:

- CAARS taskforce members continue to take a lead in ongoing development, including testing and implementation of the Common Approach;

- a steering group, derived from taskforce members, be established to continue the work of identifying, and engaging with, relevant stakeholders in the universal and targeted service sectors, and with state and territory governments; and

- resources are allocated to those professional sectors willing to actively support a process of cultural change in their professions and organisations

Members of the CAARS taskforce are well placed to take on such a leadership role by using their influence and networks to ‘champion’ the use of the Common Approach among members of their respective professions and to encourage other community leaders and organisations to promote and support roll-out of the Approach.
For the Common Approach to be successful it is of great importance that the momentum that has begun with CAARS is continued beyond the timeline of the current project, and that buy-in and engagement of relevant government departments (at federal and state/territory level) and potential user groups is established. Using Taskforce members to promote the Common Approach would ensure that testing and then implementation in selected sectors has ‘top down’ support as well as ‘bottom up’ engagement. Resourcing participating professions to actively support cultural change in their professions and organisations, and come together regularly to monitor progress and share learning, will greatly assist this process.

The ‘champions’ would be the first ones in Australia to familiarise themselves with the Common Approach and its mechanisms for needs identification, information sharing and referral and would agree to actively support its application as part of that sector/profession’s usual practice. Relevant professional associations would be encouraged to support this process by raising awareness among professional members (e.g. through circulation of the full or abridged guidance manual to all relevant professional groups and services; dissemination of relevant information in regular newsletters) and providing training in the Common Approach (e.g. lunch time seminars, establishment of a ‘helpdesk’), or building it into ongoing training and development. They would work to facilitate linkages with relevant local services and supports. Users would agree to share any lessons learned with the steering group to support the refinement and improvement of the Common Approach for later nationwide implementation.

**Testing the effectiveness of the Common Approach**

It is recommended that:

- the prototype Common Approach be tested in a minimum of two geographical areas, including urban and rural, with a range of selected professions and over a period of at least 12 months;
- a coordinator be appointed to liaise between different groups and manage allocation of resources, including communication, training and peer support for participating professions and practitioners;
- the supplementary resources required for national implementation (outlined in Section 6.4) are developed for the test sites to support the prototype testing stage; and
- continuous evaluation is built into the prototype testing stage.

In establishing effectiveness of the Common Approach, the prototype testing would serve to determine:

- whether and under what circumstances universal service providers use the Common Approach;
- what resources are required for successful implementation;
- how easy it is for universal service providers to use the different components of the Common Approach in practice; and
- how easy it is for children, young people and families to engage with the universal service providers in the needs identification and referral process.
Selection process for test sites

It is recommended that the prototype Common Approach is tested in distinct geographical areas (as opposed to nationwide testing within selected professional groups) as this will allow sounding of the important aspects of collaboration and shared responsibility between services on a local level. The Common Approach relies on services working together to deliver better outcomes for children and families, including through sharing information and using a common language and consistent approach to facilitate more effective responses, including referrals. This will require system changes at a local level, which will be best tested through a focus on a specific geographic area.

A minimum of two geographic regions within Australia is recommended. Selection could be determined through a competitive tender process, based on responses to selection criteria established by the steering group, that focus on the achievement of effectiveness as outlined above. Minimum requirements for test sites may include, but should not be limited to:

- **Involving as many groups of universal service providers as possible, supported by those professional groups committed to 'championing' the process** (see section ‘building the momentum’, above) — The Common Approach has been designed for use by a wide range of universal service providers across Australia. All groups of universal service providers consulted over the past year support the aims of the Common Approach and appreciate it as a mechanism that can help them take a holistic view beyond the boundaries of their respective professions. However, the consultations also revealed that different users would apply the Common Approach in different ways and that they face varying challenges. Consequently, it will be essential to develop an understanding of the range of issues that will be experienced by different provider groups so as to identify problems and concerns and address these prior to national implementation;

- **Covering a sufficiently large geographic area, ideally including both rural and urban areas** — It is important to assure that the selected sites cover a large enough geographic area so that the universal providers have a critical mass of children and families and practitioners with whom to use the Common Approach. The Common Approach has been designed for use in universal services wherever they are located and has not been tailored to specific locations (e.g. urban, rural). For purposes of the prototype testing, the areas selected should be large enough and varied enough to ensure a wide and diverse sample of families is reached; and

- **Testing the prototype Common Approach for a minimum of 12 months** — For the prototype testing to be effective and valuable, the test period needs to be long enough to allow for a relatively large number of people to access the process, and to ensure scope for learning from experience. In order to maximise this opportunity, including in non-urban areas, it is recommended that the duration of the prototype testing be **no less than 12 months**.
Supplementary resources required for testing the prototype Common Approach

For the prototype testing to be a representative test of the effectiveness of the Common Approach, it will need to be a prototype for national implementation. As such, the resources required to support national implementation will also be required to support implementation in the test sites, on a smaller scale. These resources are outlined in more detail in Section 6.4 and include:

- service directories of relevant information, community support and community and government services in the relevant test area;
- properly designed prototypes of the hard copy and online versions of the Common Approach;
- training materials to supplement the guidance manual; and
- a comprehensive communication strategy, including communication vehicles to raise awareness and encourage participation.

In addition, it is important to assign a Common Approach ‘coordinator’, who would function as a liaison person between different professional groups and would be responsible for assuring that the coordination and collaboration required for the Common Approach is undertaken smoothly throughout the test site. The coordinator would also be responsible for coordinating education and training sessions to participants. Training undertaken during the prototype testing would enable the available training material (see Section 6.4) to be tested with a view to improving or amending it, where necessary, prior to national roll-out.

Ongoing evaluation of the prototype testing and issues to examine

In order to provide evidence for an ultimate decision about national roll-out of the Common Approach, the prototype testing should be evaluated over the course of the program and after its conclusion. This could be done through a mixed strategy of formative and summative evaluation. A formative evaluation (also known as developmental or implementation evaluation) would assess the ongoing prototype testing and implement improvements. The formative component of the evaluation can be designed to collect data throughout the term of the prototype testing and to encourage reflection by the various participants, including universal service providers and the Common Approach coordinator. The formative evaluation should be complemented by a summative evaluation, which would be undertaken at the end of the prototype testing in order to analyse the extent to which the intended outcomes of the Common Approach were achieved.

The formative evaluation would commence at the same time the prototype tests are launched and the summative evaluation would be completed within three months of the end of the test period.

The evaluations will help identify the successes and problems during the test period and help determine what changes and improvements are warranted during and after the course of the 12-month prototype testing. This will include an assessment of the effectiveness and appropriateness of the preliminary training material and the service directory available to participants in the prototype testing (see Section 6.4). The evaluation should, among other things, focus on a number of implementation issues identified during the development of the Common Approach, including:
• the validity of the conversation prompts used in the needs identification mechanism;
• the potential to link and/or integrate the Common Approach with existing workflows and tools used by universal service providers;
• the need for a self-assessment questionnaire aimed at parents and carers, in addition to the self-assessment questionnaire for young people;
• the impact on local services as a result of the Common Approach;
• the availability of appropriate support services to respond to the needs identified; and
• the ease with which the Common Approach can be adapted to people from diverse groups, including Aboriginal and Torres Strait Islanders and CALD groups.

The evaluation would also serve to analyse the effectiveness of the Common Approach in supporting and influencing decision-making pathways by users of the Common Approach, starting with the decision of whether or not to involve a child/young person/family in a conversation about their strengths and needs through to the referral decision.

**Establishing the efficacy of the Common Approach**

*It is recommended that the efficacy of the Common Approach be tested through a rigorous research methodology such as randomised controlled trial.*

It is important to establish the efficacy of the Common Approach, i.e. its ability to do what it was designed to do, before it is accepted by the professions most likely to use it and implemented nationwide. Testing the efficacy of the Common Approach using a rigorous research methodology will identify whether it achieves its intended purpose. This would include determining whether the use of the Common Approach:

• enhances the wellbeing of children, young people and families of all cultural and ethnic backgrounds and in all geographical regions who come into contact with those universal services; and

• ultimately, leads to a reduction in referrals to the statutory sector because needs are addressed *before* a crisis occurs.

A rigorous process will be essential for making the tool an accepted standard of practice for universal providers — especially those committed to evidence-based practice. Efficacy testing could incorporate such methodologies as randomised controlled trials to compare *impact and outcomes* for children and families with whom the Approach is used with matched clients who have not accessed it. Investigation of causality pathways would also be recommended, for example, through pathways analysis of the *process* and its final outcome.
6.4 Supplementary resources for successful implementation of the Common Approach

Feedback from the professions committed to promoting and supporting the Common Approach and findings from the measures to establish its effectiveness and efficacy will contribute to further improvement of the mechanisms for needs identification, information sharing and referral prior to national implementation. Successful implementation will also be dependent on supplementary resources such as a national online directory of services, education and awareness raising measures and training tools, as well as a Common Approach website and supporting material in hard copy format. Preliminary material developed for and used during the testing and trialling stages should be enhanced and supplemented based on feedback from service providers.

The following recommendations relate to a national rollout of the Common Approach, once efficacy and effectiveness have been established and multi-sectoral commitment to cultural change secured.

**National directory of services**

*It is recommended that a national online directory of services be developed and updated regularly for use by universal service providers, so as to enhance their capacity to make adequate and timely referrals.*

It must be stated upfront that while improved information about and access to existing services will be a positive step forward, a critical concern voiced many times throughout the consultation process related to a severe lack of support services. In addition, where relevant services do exist, many are under-resourced and/or have long waiting lists or stringent eligibility criteria that act as disincentives to referral. The CAARS project acknowledges this constraint, but is not charged to address it. Nevertheless, improved resourcing for universal and targeted services will be necessary if a shift toward a public health model for protecting Australia’s children, as espoused by the *National Framework* (COAG, 2009), is to become a reality.

Information sharing and timely referral are crucial elements of the Common Approach and are prerequisites for enhancing the wellbeing of children, young people and families whose needs have been identified and where some level of support or intervention is recommended. A comprehensive national service directory would greatly assist the referral processes by ensuring that all available referral pathways are considered and more timely contact is made with support services. This should increase the proportion of children and families whose identified needs are met in a timely manner. Identification of appropriate support services is currently impeded by the lack of a comprehensive directory or database of support services encompassing relevant sectors and disciplines. Service directories currently exist in some regions and/or are made available for certain groups by local councils, organisations or certain professional groups. National databases or directories are also in existence but again, tend to be sector-specific or target particular client groups (e.g. ACOSS, Family Relationships Services Australia, Lifeline, Australian General Practice Network). However, information about, and linkages to, an appropriate range of relevant services and supports is not readily accessible by universal service providers; nor should they be expected to collect and retain this information on an individual basis.
To ensure children and families are linked to all appropriate support services, universal service providers using the Common Approach require access to information about services available across a range of sectors and at the most appropriate geographic level for that service (for example depending on the intervention needed, support may be local, regional or state-wide). It is therefore important to move away from this currently fragmented approach towards a nationally unified approach. Supports and services available in different localities vary significantly and will change over time. Therefore, funding is needed to provide an approach that allows for an initial stocktake of existing resources to be completed, the development of a comprehensive national service directory to be done and ongoing maintenance/regular updating of the national database to be routinely performed.

The recommended directory should be easily accessible to users of the Common Approach and should provide relevant information on universal and targeted services available in Australia. The directory should include capacity to search for specific services or geographic locations. A keyword search (e.g. needs identified, services required) would bring immediate results, including a description of the nature of relevant services offered, contact details, as well as information around intake requirements and service availability (for example, wait times), where available. The database should also allow for searching by postcode, name of town or region, or by clicking on a map of Australia and then zooming in to particular locations to provide an overview of all services available. Combined searches for services and locations could also be possible.

To set up a service directory, a national stocktake exercise would need to be undertaken in order to identify service providers and other stakeholders at federal, state/territory and local level, including both governmental and non-governmental organisations and services. The identification of available services could build on existing directories and databases in each state and territory and on any existing national directories, such as that used by Centrelink and the Australian General Practice Network. The database would then need to be developed and, once it is set up, updated regularly to ensure that the information provided is correct and current. This could include a facility for organisations to update information about their own services and contact details.

A national service directory is a prerequisite for the successful implementation of the Common Approach and, to achieve desired results, should be in place at the time of commencement of the national roll-out. It is expected that development of a national online service directory will take, at a minimum, one year, with a ‘skeleton’ software potential developed within six months. As a priority, information will need to be compiled and made available in the test sites for the duration of the prototype testing and ideally this localised directory would have similar functionality to the planned national directory.

**Education and training**

It is recommended that national implementation of the Common Approach be supported by the development of training tools and by communications and marketing to raise awareness of the approach. Steps should also be taken to integrate the Common Approach, or aspects of it, into professional education and training.
The Common Approach (and the guidance manual in particular) has been designed with the aim that universal services providers will not necessarily need intensive, specialised training. The consultations identified that for some professional groups training in the Common Approach may require a minimalist approach, as professionals would already have grounding in fundamental skills such as using professional judgement and building trusting relationships. However, other groups may need more formal training particularly to foster organisational cultural change and encourage widespread implementation. Training would also assist in assuring common interpretations of the needs identification mechanism.

It is recommended that training is supported through supplements to the guidance manual, such as a training DVD, an interactive training website and the development of some generic training materials (such as a staff presentation), which would help keep training costs low.

It would also be worthwhile to explore opportunities for integrating training in the Common Approach into existing professional education programs. This could include liaison with relevant professional organisations regarding training, for example, the Medical Colleges (Royal Australian College of General Practice; Royal College of Nursing Australia), tertiary courses and professional development training (eg teachers, nurses, doctors, social workers, etc).

**User-friendly and appropriate format and design**

It is recommended that the final Common Approach be made available in hard copy and online.

To maximise accessibility, the Common Approach should be made available both in hard copy and online formats. For the hard copy version, all Common Approach components will need to be graphically designed so they are visually appealing and user-friendly. The professional judgement reference point and conversation prompt tables (current Tables 5.1 and 6.1 in the guidance manual) could be provided as separate laminated sheets, whereas copies of the ‘wheel’ might be produced and distributed as ‘tear-off’ sheets. The self-assessment questionnaire will need to be user-friendly for relevant age groups.

In addition to a hard copy version, offering a web-based tool will maximise the Common Approach’s usability and access. A new website should be created that contains all necessary information about the Common Approach, including all information contained in the guidance manual chapter by chapter (through links) on web pages as well as in downloadable pdf versions. The indicators, questions and conversation prompts should be graphically displayed and easily accessible by a few mouse clicks. For example, a click on the child sphere in the physical health domain should bring up all related conversation prompts. The software could also allow universal service providers to highlight strengths and needs in the wheel electronically and for the needs identified to be linked to the referral directory. For example if several needs are identified in the physical health domain, the provider would be given links to local health services. The website could also contain links to further reading material and other local databases.
Stakeholders made a number of suggestions on where and how the self-assessment questionnaire for young people could be made available — in particular there were suggestions from young people to increase access and exposure through posting the questionnaire on websites and making hard copies widely available in locations frequented by teenagers.

For the prototype testing phase, it is recommended that the self-assessment questionnaire is made available through service providers and, more widely, in the form leaflets displayed, for instance in schools and GP waiting rooms, in the test areas. This would allow testing the questionnaire with a wider group of young people and empower them to think about their own strengths and needs. In doing this, it will be important to indicate on the questionnaire who the young person could speak to for more information, with reference to local help services.

For national implementation and subject to feedback from the prototype testing, it is recommended that the questionnaire is available online, with links through to the questionnaire web page from sites commonly used by young people.

6.5 Summary of recommendations

Table 6.1 provides an overview of the three-tiered approach recommended in this chapter in order to move from the blueprint to successful nationwide implementation of the Common Approach. These three tiers and the actual implementation itself will need to be supported by the provision of Common Approach ‘material’ (hard copy versions of guidance manual, wheel, conversation prompts etc., and website), a service directory, as well as training material.
### Table 6.1
OVERVIEW OF RECOMMENDATIONS: MOVING FROM BLUEPRINT TO IMPLEMENTATION

<table>
<thead>
<tr>
<th>Three-layer approach</th>
<th>Action required</th>
<th>Notional timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Continue the momentum</strong></td>
<td>• Establish steering group</td>
<td>Immediately (= project inception point)</td>
</tr>
<tr>
<td></td>
<td>• Steering group to select professional groups or organisations to ‘champion’ the Common Approach</td>
<td>Over the following 2 months</td>
</tr>
<tr>
<td></td>
<td>• ‘Champions’ to commence integrating the Common Approach in practice</td>
<td>Upon completion of selection process (within the next 2-3 months)</td>
</tr>
<tr>
<td><strong>Test the effectiveness of the Common Approach</strong></td>
<td>• Resources allocated to professional sectors willing to promote cultural change</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>• Select prototype testing sites through a competitive tender process</td>
<td>Within the first three months following inception</td>
</tr>
<tr>
<td></td>
<td>• Establish coordinating mechanisms (e.g. determine Terms of Reference for coordinator role and steps for project management)</td>
<td>Within the first three months following inception</td>
</tr>
<tr>
<td></td>
<td>• Commence 12-month prototype testing</td>
<td>Upon completion of competitive tender process</td>
</tr>
<tr>
<td></td>
<td>• Develop evaluation framework</td>
<td>Commence as soon as possible after inception</td>
</tr>
<tr>
<td></td>
<td>• Conduct evaluation of the prototype testing</td>
<td>Commence shortly after inception of prototype testing and finish 3 months post prototype testing</td>
</tr>
<tr>
<td><strong>Establish the efficacy of the Common Approach</strong></td>
<td>• Determine appropriate rigorous research methodology</td>
<td>Concurrent with prototype testing</td>
</tr>
<tr>
<td></td>
<td>• Undertake research to establish efficacy</td>
<td>Commence in ca. 1 year</td>
</tr>
<tr>
<td><strong>Develop a national directory of services</strong></td>
<td>• Stocktake of existing databases and services</td>
<td>Commence immediately</td>
</tr>
<tr>
<td></td>
<td>• Develop local/regional directory for prototype testing</td>
<td>Commence immediately after selection of test sites</td>
</tr>
<tr>
<td></td>
<td>• Develop national directory</td>
<td>Commence immediately after stocktake (to be completed at time of roll-out)</td>
</tr>
<tr>
<td><strong>Educate and train users of the Common Approach</strong></td>
<td>• Update directories regularly</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>• Develop training material for prototype testing (e.g. prototype of guidance manual)</td>
<td>Over first 3-6 months</td>
</tr>
<tr>
<td></td>
<td>• Refine existing material and develop additional training material and tools (e.g. DVD)</td>
<td>Alongside prototype testing (to be available at time of roll-out)</td>
</tr>
<tr>
<td></td>
<td>• Explore opportunities for integrating training into existing professional education programs</td>
<td>Commence immediately</td>
</tr>
<tr>
<td><strong>Develop user-friendly material and a website</strong></td>
<td>• Prototypes of hard copy and online versions of Common Approach for prototype testing (e.g. wheel, conversation prompts, questionnaire etc.)</td>
<td>Over first 3-6 months after inception</td>
</tr>
<tr>
<td></td>
<td>• Refine hard copy and website content and design</td>
<td>Alongside prototype testing evaluation (to be available at time of roll-out)</td>
</tr>
</tbody>
</table>

Source: Allen Consulting Group.
Appendix A

Common Approach to Assessment and Referral Taskforce

Co-convenors

The Hon. Jenny Macklin, MP  Minister for Families, Housing, Community Services and Indigenous Affairs
Professor Fiona Stanley, AC  Chair, ARACY

Taskforce Members – Government

Ms Linda Apelt  Director-General, Department of Communities, Queensland
Alternates: Ms Anna Moynihan and Ms Anne Kilner
Mr Mark Byrne  Director, Disability, Youth, Child, and Family Services, Tasmania
Mr Martin Hehir  Chief Executive, Department of Disability, Housing & Community Services, ACT
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Alternates: Mr David Cain and Dr Susan Diamond
Mr Allan Joy  Department of Health and Families, Northern Territory Government
Ms Linda Mallett  Acting Divisional Director, Policy & Planning, NSW Department of Community Services
Alternates: Ms Susan Sarlos, and Ms Susan Nicholson
Mr Paul McDonald and then Mr Michael Naughton  Executive Director, Children Youth & Families Division, Department of Human Services, Victoria
Alternate to February 2010: Mr Michael Naughton and then member
Ms Lynette Pugh  Director, Community Connect Branch, Department for Families and Communities, South Australia
Alternate: Ms Susan O’Leary
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Mr Brian Babington  CEO, Families Australia
Alternate: Ms Stella Conroy
Ms Pam Cahir  CEO, Early Childhood Australia
Ms Gillian Calvert  Commissioner, NSW Commission for Children and Young People
Ms Debra Cerasa  CEO, Royal College of Nursing Australia
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Professor Lyn Littlefield
Executive Director, The Australian Psychological Society

Ms Libby Lloyd
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Dr Bob Lonne
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Mr Paul Mason
Commissioner, Commission for Children and Young People Tasmania

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Australian General Practice Network

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CEO, Australian Childhood Foundation

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General Manager, Lifeline Australia
Alternate: Ms Rebecca Alfonso

**Taskforce meetings are co-convened by ARACY and FaHCSIA**

**ARACY**
- Dr Lance Emerson, CEO
- Ms Sue Ludwig, Programs Manager
- Dr Geoff Holloway, Research Manager
- Ms Jaya Negi, Research Project Officer
www.aracy.org.au
FaHCSIA

- Ms Tracy Mackey, Branch Manager, Children's Policy (to January 2010), then Ms Karen Wilson
- Ms Tracy Feeney, Section Manager, National Projects (to January 2010), then Ms Michelle Weston
- Ms Kerry Marshall, Assistant Section Manager

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Meeting facilitator

Mr Michael White, MW Group Consulting
Appendix B
Technical and Information Sharing Working Group

Taskforce members

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
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<tbody>
<tr>
<td>Ms Gillian Calvert</td>
<td>Child advocate (formerly NSW Commission for Children and Young People)</td>
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<tr>
<td>Dr Susan Diamond</td>
<td>WA Department for Child Protection</td>
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<td>Mr Tony Harris</td>
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<td>A/Professor Kelsey Hegarty</td>
<td>Royal Australian College of General Practitioners</td>
</tr>
<tr>
<td>Professor Lyn Littlefield</td>
<td>The Australian Psychological Society</td>
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<td>Dr Bob Lonne</td>
<td>Australian Association of Social Workers</td>
</tr>
<tr>
<td>Mr Paul Mason</td>
<td>Commission for Children and Young People Tasmania</td>
</tr>
<tr>
<td>Dr Sue Packer AM</td>
<td>National Association for Prevention of Child Abuse and Neglect (NAPCAN)</td>
</tr>
<tr>
<td>Dr Jenny Proimosa</td>
<td>Royal Australasian College of Physicians</td>
</tr>
<tr>
<td>Dr Luke Rumbold</td>
<td>Family Relationship Services Australia</td>
</tr>
<tr>
<td>Ms Susan Sarlos</td>
<td>NSW Department of Community Services</td>
</tr>
<tr>
<td>Dr Joe Tucci</td>
<td>Australian Childhood Foundation</td>
</tr>
</tbody>
</table>

Other members

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
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</thead>
<tbody>
<tr>
<td>Professor Maria Harries AM</td>
<td>University of WA</td>
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<tr>
<td>Dr Adam Tomison</td>
<td>Australian Institute of Criminology</td>
</tr>
<tr>
<td>Dr Fiona McCrimmon</td>
<td>McCrimmon Law, NZ</td>
</tr>
<tr>
<td>Dr Gail Winkworth</td>
<td>Institute of Child Protection Studies, ACU</td>
</tr>
<tr>
<td>Dr Robyn Mildon</td>
<td>Parenting Research Centre, Melbourne</td>
</tr>
</tbody>
</table>
Appendix C

‘Bureaucratic’ principles

The child and the child’s best interests are central

• Children are listened to and actively involved in all decisions affecting them.
• All children, young people and their families are treated with respect, regardless of presenting issues and cultural or social background.

An early response focuses on positive parenting and building on family strengths

• Supporting parents to raise happy and healthy children is the best way to ensure children’s and young people’s wellbeing and safety.
• A strengths-based approach builds on and fosters existing capacities, competencies and social support networks.

Shared responsibility and collaboration pave the way for effective support pathways

• The knowledge and capacity of service providers to respond early is supported by an organisational culture of shared responsibility and extends beyond immediate, job-specific duties to assist children and families to access relevant support services.
• Families, the community and service providers share responsibility for the wellbeing of children. Collaborative partnerships are developed to facilitate more timely access to holistic care and a coordinated service response.
• Responding to need means learning from the evidence of ‘what works’ and being open to creative solutions — there is no single pathway to support.

Responding to early indicators of need is the best way to strengthen families and prevent crises

• Every effort is made to assist and support families as early as possible — before problems escalate.
• Referrals and resulting support pathways focus on promoting children’s wellbeing and safety.

The resulting pathway of support is free of stigma and fosters child and family involvement

• Children and families are reassured that everyone needs support from time to time.
• Children and families are actively involved in all steps along the support pathway, from information and consent to decisions, referrals and follow-up.

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7 Where ‘child’ includes children and young people up to age 18.
Appendix D
Feedback from stakeholder consultations

The detailed findings of the consultations are summarised in this appendix by topic area.

D.1 The Common Approach overall

There was wide support for the overall aims of the approach from practitioners. Many consultation participants indicated that they already use a holistic and collaborative approach, — in particular this is consistent with good practice in the health profession, whilst Centrelink workers and counsellors in schools also indicated that they are familiar with holistic assessment approaches. However it was generally agreed that the Common Approach and the guidance manual would continue to help make the aims and practice of these approaches a reality.

While stakeholders welcomed the Common Approach and expressed their willingness to apply it, they also referred to challenges in ensuring the Common Approach is widely used and implemented. In particular, the consultation with teachers and school counsellors revealed that many teachers would not see this as part of their role and would find it difficult to include the approach in their day-to-day workflow. They did, however, observe that it was a useful conceptual tool and could be used to raise awareness among teachers and provide them with a conceptual framework. They felt that personnel with pastoral care, counselling or social work responsibilities were in a better position to actually implement the mechanism. Some members of professional groups who already use a holistic child and family assessment (such as nurses) felt that they may not use the Common Approach, or might not use all components, because it would not add much to their existing practice — although they generally acknowledged that some elements of it did add value, and that it was particularly helpful for training and education of new workers. Testing of the prototype approach should include exploration of how to link and/or integrate the Common Approach with existing workflows and tools.

The group of nurses consulted strongly felt that the approach should be used universally for all children and families as there would be a high likelihood of missing needs with a targeted approach. The adolescents consulted also noted that there might be some young people who did not come into contact with universal service practitioners on a regular basis who would not be reached.

There were also concerns expressed by several participants that the Common Approach could contribute to overloading the service system and that the necessary support services are not available. They also pointed to the risk of raising the expectations of children, young people and families to believe they would get some support when in fact there may not be any suitable avenues for this. There was a feeling among some practitioners that while early intervention and prevention were a great aim, these were difficult to achieve in practice under current circumstances, which they characterised as lacking services in key support areas and having limited access (e.g. long wait times). As such, it will be critical to explore the impact on local services and availability of appropriate support during the prototype test phase.
D.2 Vision, Aims and Principles

All the groups consulted expressed strong support for the vision and aims of the Common Approach, including the specific wording used to express these.

The overall content and themes of the principles were also supported. However several practitioners observed that the full list of principles (which included the action statements as principles at the consultations stage) was too long and wordy. There was also some divergence of views regarding the personal nature of the ‘I will’ statements. Many provider groups liked the sense of responsibility associated with the direct language but there was also recognition that it had the potential to be confronting and that the ‘I will’ statements read more like vows than like principles. This resulted in the split (proposed by one of the provider groups) into five overarching principles with underpinning statements of action focusing on bringing the principles to life and making them personal for the practitioner.

Specific suggestions for the wording of the principles included making the language on shared responsibility more active and some suggestions to make the wording ‘sharper’. This has resulted in some re-formulating of the supporting statements so that they start with a active-tense verb (see Table 2.1 in the guidance manual). There was particular support for the language around normalising the need for support.

D.3 The guidance manual

Guidance manual overall

The guidance manual was found to be clear, comprehensive, well presented, practical and easy to follow. Many participants in consultations had no prior knowledge of the Common Approach and conveyed that they found it easy to read and comprehend. In particular, there was support for the strengths-based language and encouragement of the practitioner to be confident to think laterally and take responsibility for a holistic response to the child/family.

Most practitioners agreed that while it was lengthy, all of the information was necessary. The one group that strongly supported a shorter document were the teachers and school counsellors and a summary document (or ‘essential guide’) was developed in response to their feedback that something concise was needed to give a conceptual overview of the approach. There was also some support for a flow chart to capture key actions and the flow of events – although others observed that the wheel achieved this to some extent by providing a one page visual guide.

In particular, several user groups identified that the guidance manual would be important for raising awareness and for education and training of practitioners who have limited experience of identifying needs and risk, including new practitioners. An online version would be particularly useful in this regard. The case studies were also found to be a helpful component.
**Needs identification mechanism overall**

The needs identification mechanism was found to cover most aspects of life appropriately. In particular, its ability to cross over different ages and stages of life and to cover both children and parents/carers was thought to be particularly valuable. The one area that may need to be strengthened in the future was that relating to issues of ‘risk’, such as family violence. The indicators, prompts and questionnaire were found to be somewhat tentative regarding these more sensitive issues.

The overall framework and the components were found to fit well with existing tools and processes as they are in keeping with comprehensive family assessments. The components of the needs identification mechanism were found to be useful complements to the overall approach and to provide practitioners with a range of possible avenues for identifying strengths and needs. It was also noted that relationship building with families would be critical to the success of the approach. This would include listening and observing families over a period of time and not approaching this as a one-off assessment. It was also noted that, although needs can be identified successfully, there may be difficulties addressing some issues due to existing processes and/or lack of commitment and engagement from key service providers (for example regarding bullying in school).

The wording of the wheel, indicators and conversation prompts was found to be more suitable for older (i.e. school age) children and there was a view that there could be better coverage of issues for younger children. This included a proposal to produce different versions of the mechanism for different age groups (perhaps under-5s, 5-12 and adolescent), which would allow greater tailoring to each group. Additional indicators and prompts have been added to better address the issues for younger children. Further tailoring and/or adaptation was also proposed for Aboriginal and Torres Strait Islander and CALD groups and other special interest groups and could be considered for the prototype testing stage.

The consultations also highlighted that different provider groups may use the mechanism in different ways. The overall approach was easier for some practitioners to understand and use than others — in particular it may be more difficult for those less familiar with the ecological model of child development — and there were some concerns about the time it would take for busy practitioners to read through the detailed instructions. Some provider groups indicated they were unlikely to delve far into issues that were outside their existing practice, whilst others indicated it would help them explore issues with which they are currently less familiar. It was also thought to be helpful in providing a framework for information gathering, which was often a necessary first step to securing support under existing processes in some jurisdictions.

**Wheel**

The feedback on the wheel was overwhelmingly positive from universal providers, with many consultation participants finding it to be a very helpful visual representation, which successfully captures the ‘whole of life’ concept. Its ability to be used differently over time to provide a dynamic representation of needs and strengths was also appealing.
Some groups felt it would be **useful for engaging a family** and helping them to understand the broader context of need and the rationale behind the questions. It was also identified as being suitable for use in a busy medical practice. However, some providers observed that the wheel was **quite wordy** and that it may therefore require a simplified version, a pictorial version and/or translation for some special interest groups.

There were some suggestions for rewording or adapting the issues in the wheel, particularly those that appeared more negative. There were also suggestions for additional issues, particularly to address the needs of younger children. These were taken on board where possible, including by adding or adapting the indicators in the professional reference point (rather than in the wheel), particularly for some issues proposed which would not apply across all age groups of children but which are important for some groups.

The wheel was also tested with the group of adolescents. They did not find it a helpful or thought-provoking tool and much preferred the questionnaire for engagement regarding their strengths and needs (discussed later).

**Conversation prompts**

The range of conversation prompts was praised and they were generally thought to provide **good and useful starting points** for a discussion. However, there were some concerns about the time involved in discussing these issues at this level of detail and there was a view that most practitioners would not have time to ask many of the questions. There were also some suggestions for **additional prompts** — in particular to cover children of different ages and different situations. Although extensive additions have not been made at this stage, the questions that are aimed at certain age groups have been more clearly identified.

Concerns raised included the **skills and experience** required to handle responses to questions, particularly if sensitive issues emerged. This would require experience and training which not all universal practitioners have — either because of inexperience in this area or because their core job did not require this level of skill. However, the view was also expressed that the prompts would be of most value to those starting out in their careers by providing a way to address these challenging issues.

There were many proposals to **refine and amend the wording** of the conversation prompts, in particular to make the questions **softer, more open, more positive and less complex**. This included suggestions to move away from asking about frequency (e.g. ‘how much’, ‘how often’) because these questions can be more challenging to ask and answer and are less effective in promoting an open conversation. These questions are however useful for a questionnaire approach. These comments have been reflected in the wording of the prompts and the guidance manual. There were also proposals to provide more detail and practical examples of **developmentally and culturally appropriate questioning techniques**. This should be explored further during the prototype testing phase.
The questionnaire

Generally speaking, the questionnaire was well received by adults and young people. However, there were some critical issues that needed to be addressed with the original questionnaire in terms of its presentation and the potential implications of certain answers.

Adolescents found that the questionnaire could be completed in a short time and was insightful. They considered the questionnaire to be an ‘eye-opener’ that made them think about issues in their lives and consequently, which of these issues they would like to talk through with someone. Young people said that they would prefer to receive the questionnaire to take home rather than complete it with the practitioner concerned. They also observed that the questionnaire was less confronting and more intuitive than the actual ‘wheel’.

Some suggestions provided by young people included that it could be posted on the Kids Helpline website, as well as each jurisdiction’s Education Department website. They noted that many young people would have access to the questionnaire through these websites.

Young people made many comments about the design and format of the questionnaire. They noted that the original colour scheme — where negative answers were coloured red and positive answers green — was too confronting and young people would associate red answers as being ‘wrong’. Added to this, they said that positive and negative answers should be alternated on the page so that children that were not continually ticking one side of the page.

Young people noted that some questions were confronting, particularly in the safety domain. In a related point, they said that some of their friends would probably not answer questions, or may answer them dishonestly if they were worried about the actual answer. A similar point was that a non-answer would probably need to be perceived by the practitioner as an issue for a young person. There were also concerns that some of their peers would not access the questionnaire, as they are not close to any adults. For these instances, web access was considered to be important. Regardless of how questions are actually answered, young people agreed that it was useful for their peers to have a resource such as the questionnaire available to them.

Practitioners noted that the questionnaire provided valuable information on a child/young person’s protective factors and that it provided a good starting point for engaging in conversation with children/young people. They emphasised that it was important that the questions were phrased in positive, non-judgemental language. However several user groups also expressed views that it would be better to discuss these issues face-to-face rather than ask a child to complete the questionnaire on their own. If the questionnaire was given to a child to take away it was thought unlikely that they would return to discuss their answers with the practitioner. There was also a risk that the process of completing the questionnaire would make vulnerable young people feel worse about themselves if they did not have someone to talk to about their answers at the time. As a result, most practitioners felt that the questionnaire should be used as part of a facilitated process.
There were concerns about the notion of informed consent and cases where there may be serious implications from some children’s/young person’s answers — for instance, the need to notify child protection agencies, which would certainly be the case if certain answers were give to some of the questions in the safety domain. This concern particularly related to the information in the introductory section of the questionnaire which suggested that the answers would remain confidential, when in fact this would not always be the case. The introductory section to the questionnaire and the accompanying guidance for practitioners (Chapter 7 of the guidance manual) have subsequently been updated to explain these issues and the potential implications more clearly.

The nature of some of the questions and potential answers that service providers may receive could place high responsibility on service providers if issues are not followed through appropriately. This issue raised concern as to whether it was appropriate to be used by all service providers.

The feedback from adolescents suggests that the self-assessment questionnaire is an important component of the needs identification mechanism that puts the child at the centre of the process and empowers them to identify their own strengths and needs. However it is acknowledged that there are risks and challenges in how practitioners use it, and how the information accompanying the questionnaire explains its purpose and implications to children. The guidance manual was updated following the consultations to encourage practitioners to take a flexible approach. The circumstances in which the questionnaire is used should be explored further through prototype testing to further explore these risks and how to overcome the challenges.

It was also noted that the questionnaire would need to be adjusted to be more user-friendly for special priority groups. For example, the questionnaire could be translated into a number of languages or could be available in other forms, for example a pictorial version suitable for children/young people with lower literacy levels.

D.4 Information sharing and referrals

The information sharing and referral section in the guidance manual was also subject to significant concern from practitioners. Some of this concern related to the overall level of detail. Many consultation participants felt that this section of the manual needed to give more specific information about accessing local information and local services and how the tools and referral processes dovetail with what is already in place. However, they also acknowledged that this would need to be done at a local level and therefore might not be suitable for a national document. Some additional examples of sources of information regarding local services and referral processes have subsequently been incorporated into the guidance manual. In addition, development of an online version of the guidance manual could present an opportunity to link the guidance explicitly to local or state guidelines and tools in each jurisdiction.

There were also concerns regarding specific issues, which primarily related to informed consent, the concept of ‘warm referrals’ and the availability and effectiveness of referral pathways. For each of these issues, it was identified that greater clarity was needed in the guidance manual.
Informed consent was a key issue in consultations. Each Australian jurisdiction has its own legislation and protocols and their is no standard at which a young person is considered able to provide consent. It was suggested that the guidance manual provide access to information on state- or territory-specific protocol, in the form of links or some other form of template showing jurisdiction differences. The guidance manual has taken the approach of a high level outline of ‘golden rules’ for information sharing. Practitioners may also have access to guidelines and information specific to their profession or organisation.

While some practitioners welcomed the concept of a ‘warm referral’ others were less enthusiastic for two reasons. The first was that the practitioner may simply not have the time or capacity to walk through a referral with the child/family. The second reason was because they would prefer the child/family to be encouraged to take action themselves by making their own appointments rather than risk building a culture of dependence. Examples of instances where warm referrals would work well for both practitioners and families included children’s and families’ services in Indigenous communities.

The term ‘friendly referral’ was suggested as a replacement for ‘warm’ referrals and it was stated that regardless of what type of referral was used to take forward an issue, children/young people/families should not experience delays in obtaining support. The term ‘friendly’ referral was subsequently added to both the report discussion and guidance manual.

There was some uncertainty from practitioners in regard to the referral processes as detailed in the guidance manual. It was suggested to add in some information on how a conversation about referral (and information sharing) could be started. Some questioned whether there really was a pathway for all circumstances and noted that the guidance manual should encourage practitioners to exercise community links if service referrals were not immediately apparent. Another suggestion was to add information about referral options in the guidance manual, in the following possible formats:

- links to websites;
- a national stocktake — this would require funding;
- directions on how to access local information; and
- information on how the guidance manual links in to other tools, such as existing child or family assessment tools.

These suggestions have been built upon in the recommendations for prototype testing and trialling the Common Approach, outlined in Chapter 6.
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OECD 2009, Doing Better for Children


SECTION B:

Final guidance manual for the Common Approach for identifying and responding early to indicators of need
A Common Approach for identifying and responding early to indicators of need

Guidance manual for universal service providers

June 2010

Final guidance manual to the Common Approach to Assessment, Referral and Support (CAARS) Taskforce and the Australian Research Alliance for Children and Youth (ARACY)
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About this guidance manual

The majority of parents and families have the capacity and the motivation to raise healthy and happy children. But for every parent and every family, raising children has its challenges. Everyone needs some help sometimes. The Common Approach is a way to identify early signs that a child, young person or family is in need of support, and early action to link that child, young person and/or family with adequate support – before problems escalate into crises.

This guidance manual is designed to help universal service providers, who are the primary users, to understand what the Common Approach is trying to achieve. It describes how to apply the Common Approach in practice and how to use its mechanisms for needs identification, information sharing and referral.

The manual can be read as a whole, but will not necessarily be read in its entirety by all readers. The first three chapters of this guidance manual provide important information on what the Common Approach seeks to achieve, details the practice principles and overviews each of the components. Practitioners should use these chapters as a guide for identifying the material in the rest of the manual that will be most relevant to them. The chapters on each of the separate components (Chapters 4 through 8) are stand-alone and universal service providers may refer to these as necessary.

For an overview of the different components of the Common Approach and where relevant information can be found, see Figure A.

An abridged version of the manual, the Summary Guide, is available at the front of this document. It provides a brief overview of the purpose of the Common Approach and how to use the needs identification mechanism. It should be cross-referenced with the detail provided in the full Guidance Manual.
Figure A
OVERVIEW OF THE DIFFERENT COMPONENTS OF THE COMMON APPROACH

Source: Allen Consulting Group.
Part 1

Summary guide
Summary Guide

This Summary Guide is an abridged version of the Guidance Manual for the Common Approach. It provides a brief overview of the purpose of the Common Approach and how to use the needs identification mechanism. It should be cross-referenced with the detail provided in the full Guidance Manual.

Purpose of the Common Approach

The majority of parents and families have the capacity and the motivation to raise healthy and happy children. But for every parent and every family, raising children has its challenges. Everyone needs some help sometimes.

The Common Approach aims to increase universal service providers’ capacity to provide children, young people and families with the assistance they need as early as possible, to enhance child wellbeing. It consists of:

- a mechanism to identify early signs that a child, young person or family is in need of support (the ‘needs identification mechanism’); and
- guidance to facilitate early action to link that child, young person and/or family with adequate support, before problems escalate into crises (‘information sharing and referral guidance’).

The vision, aims and principles for the Common Approach are detailed in Box A.

Box A

VISION, AIMS AND PRINCIPLES FOR THE COMMON APPROACH

<table>
<thead>
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<th>Vision</th>
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<td>Promoting the safety and wellbeing of children, young people and families by identifying and responding early to indicators of need.</td>
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<th>Aims</th>
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<tr>
<td>To give universal service providers a way to identify and respond to early indicators of need that is simple, easy to use, flexible, evidence-based and adaptable for use in different services.</td>
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<td>To strengthen collaboration among service providers by promoting a common language and consistent approach to information sharing and referral within and between services.</td>
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<tr>
<td>To facilitate a timely and child-and-family-friendly pathway of support for children, young people and their families.</td>
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<th>Practice Principles</th>
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<td>The child’s and the child’s best interests are central.</td>
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<td>An early response focuses on positive parenting and building on family strengths.</td>
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<tr>
<td>Shared responsibility and collaboration pave the way for effective support pathways.</td>
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<tr>
<td>Responding to early indicators of need is the best way to strengthen families and prevent crises.</td>
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<tr>
<td>The resulting pathway of support is free of stigma and fosters child and family involvement.</td>
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Source: Allen Consulting Group

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A ‘child’ includes children and young people up to age 18.
When to use the Common Approach

The Common Approach builds on your own day-to-day practice. It is designed for use when you have a concern that a child, young person or family may require a level of support not normally provided by your service, or when you have identified the need for early response to a particular concern and want to consider the appropriate action to take. It should therefore be used in a selective way; it is not designed for use as a universal screening tool for all children, young people or families you come into contact with.

The Common Approach, and the needs identification mechanism developed as part of the Common Approach, is in no way intended to replace an assessment of risks and, where it appears necessary and appropriate, mandatory reporting and referral to the statutory sector.

The ‘wheel’ — the overarching framework for the Common Approach

The central component of the needs identification mechanism is the ‘wheel’, which presents a holistic view of a child’s or young person’s life (see Figure B).
The child/young person sits at the centre of this framework (wheel). The surrounding circles represent the child’s family and the wider community. Each sphere of the child’s or young person’s life is divided into six wellbeing domains, which form the sectors of the wheel.

Both needs and strengths may exist in each domain and each sphere. Example indicators are incorporated into the wheel to provide a reference for the types of issues that may be relevant in each segment.

The wheel can help you think about different aspects of a child/young person’s life and can also be used to record the strengths and needs identified — for example, by circling the segments in which strengths lie in one colour and the needs in another.

How to use the Common Approach

Strengths and needs should be identified in collaboration with children, young people and their families. It is critical that you:

• discuss the issues you have identified with the child, young person or family member — highlight and praise their strengths, as well as being specific about your concerns;

• obtain their explicit consent to share their personal information with you;

• seek their views on their own strengths and any areas where they consider they might need assistance; and

• ascertain whether they wish to take steps toward addressing these issues.

The issue of consent is particularly important. Some key points to note are outlined in Box B.

Box B

OBTAINING INFORMED CONSENT: KEY POINTS

• You should be very clear about the purpose of the discussion with a child, young person or parent/carer and potential implications of sharing information of a personal nature. Your starting point is one of respect for your clients’ opinions and concerns and acknowledgement of the importance of their own active involvement in discussions and decision-making.

• In general, information you obtain can only be shared with the informed consent of the young person or family in question.

• The only exception to this would be cases where the information you are given indicates that ethical or legal thresholds may have been reached. In such cases you need to be guided by existing guidelines, ethical codes and legislation relevant to your profession and jurisdiction.

• For children under 16, you will generally need the consent of the parent(s) to share information. However it is important to also try to determine the views and wishes of the child or young person and, depending on their age and capacity and the legislation in your jurisdiction, their consent may be sufficient.

Further information regarding informed consent is provided in Chapter 8.
Components of the needs identification mechanism

The ‘wheel’ presents the overarching framework for needs identification. It is supported by three additional components:

- A professional judgement reference point comprising high-level example indicators of need and questions, which can help to validate an initial concern. These questions are for you to consider before engaging in a conversation with the child/young person or family (see Chapter 5);

- Conversation prompts, i.e. a menu of sample questions, to assist you in engaging in a conversation with children, young people and families about their strengths and needs (see Chapter 6); and

- A self-assessment questionnaire for adolescents to use to identify their own strengths and needs as part of, or ahead of, a discussion with you or another universal service provider (see Chapter 7).

These components and accompanying guidance on their use are provided in the guidance manual in the chapters indicated. In addition, practical tips and example case studies are provided in Chapter 9.

Information sharing and referral guidance

The Common Approach is intended to strengthen collaboration between services; promote shared responsibility among universal service providers, families and the wider community; and support early preventative action. The referral and support pathways that may be appropriate for children, young people or families will therefore include a range of informal supports as well as specialised services.

You should consider the following pathways for addressing underlying needs, in discussion with the child, young person or family:

- action the child and family can take themselves;
- informal supports available from family members or neighbours;
- community support such as informal support networks, local sporting clubs, community centre activities;
- services and supports you or your colleagues can offer;
- other universal services; and
- specialist and targeted services.

Guidelines for making optimal referrals and for sharing information are outlined in Chapter 8, along with details of possible sources of information on local support services.
Part 2

Full guidance manual
Chapter 1
Overview of the Common Approach

What is the Common Approach?

The Common Approach aims to promote the safety and wellbeing of children, young people and families by linking them with adequate support services before needs escalate into crises. The instrument has been designed with a view to increasing practitioners’ capacity to provide children, young people and families with the assistance they need as early as possible.

The Common Approach focuses on child wellbeing by providing flexible mechanisms and a consistent language for identifying and responding early to indicators of need among children, young people and their families. It aims to make more and better use of universal services, targeted services and other community supports.

Users of the Common Approach can help achieve a timely and child- and family-friendly pathway of support for children, young people and their families who, without such support, may become increasingly vulnerable. Identifying needs early and facilitating a link with appropriate support services should be seen as a normal process for children, young people and families.

The Common Approach is in no way intended to replace an assessment of risks and, where it appears necessary and appropriate, reporting (including mandatory reporting) and referral to the statutory sector. In the Common Approach practitioners initiate and facilitate a conversation with the child and family aimed at identifying potential needs and referring them to appropriate support services. What sets this approach apart is that the child, young person and family are the ultimate decision-makers. They decide whether they want to have the ‘needs-identification conversation’ in the first place, and whether and in what kind of follow-up action they would like to engage.

The Common Approach builds on the notion that providers in the universal sector are ideally placed to build trusting relationships with families and to work with them to seek appropriate support when the need arises. Normalising the journey between universal and targeted services based on each family’s need is an essential part of a successful approach.

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2 The term universal services refers to the practice of providing a baseline level of services to every resident of a country. It includes services such as provided by doctors, maternal and child health nurses, teachers, childcare workers etc.

3 The targeted sector provides services that target people with special needs, i.e. people who are in greater need of support. This includes those services providing drug and alcohol support, mental health services, homelessness/housing assistance, crisis care, etc.
Who could use the Common Approach?

The Common Approach, together with its needs identification mechanism, is geared towards universal service providers who are most likely to come into daily or regular contact with children, young people and families. The instrument has been designed with a view to increasing practitioners’ capacity to provide children, young people and families with the assistance they need before problems escalate into crises.

Practitioners using the common approach are likely to include:

- general practitioners, paediatricians and other health professionals;
- teachers and school counsellors/psychologists;
- child care workers, including long-day care, family day care, OOSHC;
- preschool providers and kindergarten teachers;
- Centrelink staff; and
- child and family health nurses; and
- may also include others, e.g. police, midwives, emergency staff in hospitals, playgroup facilitators.

As a universal service provider, the Common Approach will:

- support and guide you in identifying and responding early to the needs of children and families to prevent child abuse and neglect occurring, by providing mechanisms which are simple, easy to use, flexible, evidence-based and adaptable for use in different services; and
- assist you to collaborate with other service providers by promoting a common language and consistent approach to information sharing and referral within and between services.

In addition, the approach may also be helpful in targeted services and other community supports as a way of sharing information and using a common language between different targeted service providers.

When to use the Common Approach

The Common Approach encourages you to consider the strengths and needs of children, young people and families you come into contact with and to look for early indicators of need that may require further support.

The mechanisms within the Common Approach — the needs identification mechanism and the mechanism for information sharing and referral — are designed for use when you have a concern that a child, young person or family may have a need requiring further support, or when you have identified a need and want to consider the appropriate steps. The mechanisms should help you:

- validate your initial concern;
- consider the child’s and family’s strengths;
- consider the wider needs of the child and family; and
• identify the appropriate course of action, including relevant support and referral pathways, drawing on the child’s and family’s strengths and capabilities and making decisions jointly with them.

The Common Approach and its mechanisms should therefore be used in a selective way; it is not designed for use as a universal screening tool for all children, young people or families you come into contact with (see Figure 1.1).

If you have a concern that a child is being abused or neglected you should follow the statutory reporting processes in your jurisdiction. The Common Approach is designed to assist practitioners to respond to identified need and facilitate additional support as required. The children, young people and families identified for such support are those who are not immediately ‘at risk’ in the statutory sense – the focus is on prevention of child abuse and neglect.

Please note:

The Common Approach, and the needs identification mechanism developed as part of the Common Approach, are in no way intended to replace an assessment of risks and, where it appears necessary and appropriate, mandatory reporting and referral to the statutory sector. Use of the Common Approach assumes a practitioner has a working knowledge of existing legislative obligations and will turn to them when it becomes apparent that the identified ‘need’ is actually a case for mandatory reporting.
How to use the Common Approach

The Common Approach is as an instrument designed for use by all universal service providers that is applicable for all population groups. That is, the instrument is not tailored to specific professional groups or to children, young people and families of different cultures, ethnic groups or language backgrounds. As a universal service provider you should use your expertise to adapt your conversation with the child/young person/family to reflect the differing experiences and needs of these groups.

The way in which the Common Approach is used shouldn’t depend on where you are located, or what particular service you provide. It is critical that all service providers who use the Common Approach have the same understanding of what it is out to achieve and how it should be used. This is because, used consistently, the Common Approach will improve:

• consistency in identifying the underlying needs of children, young people and families who, without early support, may experience even more complex problems in the future;
• community understanding that all families need help sometimes and should be assisted to obtain it;
• quality of outcomes for children, young people and families;
• access to services and supports for children, young people and families, which build on their strengths and capabilities; and
• collaboration with children, young people and families in decision-making and planning the next steps.

The Common Approach consists of several components that are designed to help you understand and apply the approach:

• **Vision and aims** of the Common Approach as well as **practice principles** that will guide you in your endeavour to identify the needs of children, young people and families early (these are described in Chapter 2);

• **Needs identification mechanism**, the instrument that assists you in identifying needs early and provide children, young people and families with the assistance they need before problems escalate into crises (the needs identification mechanism is described in Chapter 3, with more detailed information on individual components of the mechanism provided in Chapters 4-7); and

• Mechanisms that guide you in **sharing information and making relevant referrals** (these are described in Chapter 8).

The Common Approach is designed as a tool applicable across all population groups. As such, it does not currently provide specialist advice for engaging with special interest groups including Aboriginal and Torres Strait Islander groups. For example, in remote Aboriginal and Torres Strait Islander communities, universal service providers may need to modify the language or adapt the way they use the wheel to ensure that families understand the process.
Chapter 2

Vision, aim and practice principles

Vision of the Common Approach
Promoting the safety and wellbeing of children, young people and families by identifying, and responding to, early indicators of need.

Aims of the Common Approach

• To give universal service providers a way to identify and respond to early indicators of need that is simple, easy to use, flexible, evidence-based and adaptable for use in different services.

• To strengthen collaboration among service providers by promoting a common language and consistent approach to information sharing and referral within and between services.

• To facilitate a timely and child-and-family-friendly pathway of support for children, young people and their families.

Practice principles
The principles for using the Common Approach (see Box 2.1) are overarching; you should keep them in mind when working with children, young people and/or families to identify their strengths and needs. In particular it is critical that children, young people and/or families are involved in the identification process and that you consult with them and seek their agreement when making decisions and referrals.

Box 2.1
COMMON APPROACH PRACTICE PRINCIPLES

- The child and the child’s best interests are central
- An early response focuses on positive parenting and building on family strengths
- Shared responsibility and collaboration pave the way for effective support pathways
- Responding to early indicators of need is the best way to strengthen families and prevent crises
- The resulting pathway of support is free of stigma and fosters child and family involvement

Table 2.1 outlines how these principles apply in practice to you, as a universal service provider working with children, young people and families.
Table 2.1
THE PRINCIPLES IN PRACTICE

<table>
<thead>
<tr>
<th>Principle</th>
<th>How the principles apply to you</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The child and the child’s best interests are central</strong></td>
<td>I will aim to:</td>
</tr>
<tr>
<td></td>
<td>• <em>listen</em> to the child and involve them actively, and according to their ability, in all decisions affecting them.</td>
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<td></td>
<td>• treat all children, young people and their families with <em>respect</em>, regardless of age, presenting issues and cultural or social background.</td>
</tr>
<tr>
<td></td>
<td>• be alert to the possibility of the <em>child’s subjective experience</em> of their wellbeing being different from that reported by their family.</td>
</tr>
<tr>
<td><strong>An early response focuses on positive parenting and building on family strengths</strong></td>
<td>• <em>support parents</em> to raise happy and healthy children, as this is the best way to ensure children’s and young people’s wellbeing and safety.</td>
</tr>
<tr>
<td></td>
<td>• use a <em>strengths-based approach</em> that builds on and fosters existing capacities, competencies and social support networks, wherever possible.</td>
</tr>
<tr>
<td><strong>Shared responsibility and collaboration pave the way for effective support pathways</strong></td>
<td>• <em>inform</em> myself of relevant support services for children and families to expand my own knowledge and capacity to respond early.</td>
</tr>
<tr>
<td></td>
<td>• <em>take and share responsibility</em> for the wellbeing of children by responding early and assisting a child and family in need to access relevant support services, even where this means taking action beyond my immediate, job-specific duties.</td>
</tr>
<tr>
<td></td>
<td>• <em>collaborate</em> with families, other service providers and the local community to assist the child and family. By working in partnership we will facilitate more timely access to holistic care and can deliver a coordinated service response.</td>
</tr>
<tr>
<td></td>
<td>• <em>learn</em> from the evidence of ‘what works’ and be open to creative solutions I have not previously considered — there is no single pathway to support.</td>
</tr>
<tr>
<td><strong>Responding to early indicators of need is the best way to strengthen families and prevent crises</strong></td>
<td>• <em>assist and support</em> children and families as early as possible — before problems escalate.</td>
</tr>
<tr>
<td></td>
<td>• <em>promote</em> children’s wellbeing and safety through referrals and resulting support pathways.</td>
</tr>
<tr>
<td><strong>The resulting pathway of support is free of stigma and fosters child and family involvement</strong></td>
<td>• <em>reassure</em> children and families that everyone needs support from time to time.</td>
</tr>
<tr>
<td></td>
<td>• <em>involve</em> children and families actively in all steps along the support pathway, from information and consent to decisions, referrals and follow-up.</td>
</tr>
</tbody>
</table>
Chapter 3
Overview of the needs identification mechanism

What is the needs identification mechanism?

The needs identification mechanism gives universal service providers an instrument that:

- confirms an initial concern or highlights issues that might otherwise go unidentified;
- identifies the strengths, protective factors, concerns, and unmet needs of children/young people/families; and
- facilitates a pathway to appropriate support services, in either the universal sector, the targeted sector or in the broader community.

The needs identification mechanism comprises four components that can be used together or individually. These four components, designed to assist you to identify needs in children/young people/families, are:

- The 'wheel' — The wheel is designed as an aid to help you think about different aspects of a child/young person’s life, including those areas that are outside your immediate area of professional expertise, and to structure your thinking. The wheel can be used to guide a conversation with the child, young person or family and to seek their input.

- A professional judgement reference point — The professional reference point comprises high-level example indicators of need and questions for use by the practitioner before engaging with the child/young person/family. They serve to validate an initial concern that a child, young person or family may have a critical need requiring further support;

- Conversation prompts — Conversation prompts assist the practitioner in engaging in a conversation with children, young people and families about their strengths and needs; and

- A self-assessment questionnaire — The self-assessment questionnaire is for use by children, young people and families who can complete it by themselves. This can occur either upon invitation by the practitioner or at the child/young person/family’s own instigation. The results are then discussed with the practitioner who will help to clarify strengths and needs identified and explore options for potential next steps.

As a practitioner using the needs identification mechanism, you should be familiar with each component and be able to adapt them depending on the circumstances of each child and family. The mechanism with its different components recognises that, across different professions, there will be different types of contact and relationships with children, young people and families.
How to use the needs identification mechanism

The relationship between the wheel, the professional judgement reference point and the conversation prompts and questionnaire is illustrated in Figure 3.1.

Figure 3.1
COMPONENTS OF THE NEEDS IDENTIFICATION PROCESS

The needs identification mechanism with its different components is designed to be flexible and adaptable to different circumstances and used by a wide range of service providers. It is not expected that you would use all components in every case or in the course of a single discussion. Needs identification will often flow from your relationship with the child or family and may be an ongoing process with different components being used at different times over the course of several discussions with the child or family. Some examples of how you could use the different components of the needs identification mechanism are provided in Box 3.1.

Box 3.1
USING DIFFERENT COMPONENTS OF THE MECHANISM: SOME EXAMPLES

- If you become aware of a specific need through the course of your professional relationship with the child/young person/family, you could ask the child/young person/family to complete a self-assessment questionnaire and then have a discussion about the results and next steps;
- If you are very familiar with one or two domains of the child/young person’s wellbeing (for example their health) you may want to have a discussion with the child/young person that covers the other four or five domains, and not the ones you are already familiar with. The conversation prompts for engaging with children, young people and families may be useful in this instance; and
- If you know the child, young person or family well, you may be able to simply use the wheel in an informal conversation, working with them to highlight specific needs and strengths they may have.
To help you get started in identifying strengths and needs, you can consider the ‘checklist’ in Box 3.2. In particular, this serves to emphasise that strengths and needs should be identified in collaboration with children, young people and their families. If you have difficulty getting the child or parent to engage in a discussion, you should consider how to support them to engage. This may involve persuading them of the value of a discussion; identifying a colleague or another service provider with whom they may be more comfortable having a conversation and encouraging or supporting them to have that discussion; or approaching another family member if appropriate (such as the child’s parent).

**Box 3.2**

**‘GETTING STARTED’ CHECKLIST**

- Check that the child/family is happy to have this discussion with you and make sure they are comfortable about the timing and location of the discussion
- Consider which component/s are most likely to be helpful – remember you can be flexible how you use the Common Approach, and whether you involve the child/young person or parent/carer or both
- Start on the premise that you are building a relationship of trust – listen actively, explain carefully, be observant and invite comments and questions. Take the conversation a step at a time, introduce new ideas simply and neutrally
- Be positive and supportive, highlight and praise children and families for their strengths and emphasise that it is normal to need help some of the time
- If needs are identified in the ‘child’ sphere you should ascertain the child’s/young person’s views if they are old enough to express them and jointly find ways to address the needs
- If you identify that a family member has needs that, if not addressed, could adversely affect the child/young person’s wellbeing (e.g. family member was made redundant at work and now suffers depression), you may discern that the best way to support the child/young person will be to suggest relevant support for the family member.

Specific case study examples of how the needs identification mechanism and its different components may be used are provided in Chapter 9. The following chapters contain an explanation of how the wheel, the professional judgement reference point, the conversation prompts and the self-assessment questionnaire may be used to assist you in identifying needs.
Chapter 4

Identifying strengths and needs with the ‘wheel’

Using the ecological model of child development in the form of a ‘wheel’, the needs identification mechanism presents a holistic view of the child’s/young person’s life. It comprises three concentric circles that represent three spheres: The child/young person sits within the centre circle and is surrounded by their family and then the wider community, represented by the outermost circle. Each sphere of the child’s/young person’s life is divided into six wellbeing domains, which form the sectors of the wheel:

- physical health;
- mental health and emotional wellbeing;
- safety;
- material wellbeing;
- learning and development; and
- relationships.

The wheel is shown in Figure 4.1. Both needs and strengths may exist in each domain and each sphere. Example indicators, i.e. examples of the issues relevant for each sector are incorporated into the wheel to provide a reference for the types of needs that should be considered.
Figure 4.1

NEEDS IDENTIFICATION MECHANISM: THE ‘WHEEL’

Source: Allen Consulting Group.
While the four components can be used singly or in combination, the wheel is designed to be the centrepiece. The wheel can be the starting and/or end point of the needs identification process, that is, the wheel can be used:

- **during** a conversation with the child/young person/family, with or without the use of conversation prompts. During the conversation you may choose to refer to the domains, spheres and example indicators in the wheel as a guide to identifying and discussing needs and strengths, and ask questions along these lines. Alternatively, where you wish more guidance in terms of how to phrase the questions you can use to identify strengths and needs, you can refer to the conversation prompts that have been developed for each example indicator (the use of conversation prompts is described in more detail in Chapter 6). In both cases, the wheel can serve as a visual aid to support the conversation, and strengths and needs can be circled in different colours; or

- **in conjunction with the self-assessment questionnaire** and the conversation that takes place after the child/young person/family brings back the results. As discussed above, you can then use the wheel to circle strengths and needs that are being identified on the basis of the questionnaire results and the subsequent conversation; or

- **after** a conversation about strengths and needs in case you choose not to use the wheel during the conversation. In this case, the wheel could serve to record the strengths and needs that were revealed in the course of the conversation, with the wheel being a visual aid supporting the decision-making process about next steps, including referral (see Box 4.1).
Box 4.1

RECORDING STRENGTHS AND NEEDS

The ‘wheel’ can be used to record the needs and the strengths identified by circling or electronically highlighting the sectors in which the needs and strengths lie (e.g. using different colours for circling strengths and needs – as illustrated in Figures 9.1, 9.2 and 9.3). For example:

- If the needs identified lie with the child/young person and the response required would focus on the child/young person (e.g. the child/young person has a health condition or is struggling at school), then the relevant child sector should be highlighted or circled as a need;
- If the needs identified indicate that the parent/carer or another family member requires additional support (e.g. the mother has mental health needs or the child/young person is malnourished), the family sector should be highlighted or circled as a need;
- If the needs identified relate to the family’s access to services and/or relationships with the wider community (e.g. the family have housing-related needs or the family has needs relating to their social support networks), the community sector should be highlighted or circled as a need; and
- If unsure whether the need relates to the child, young person or the family, or if the needs are across all the spheres, the whole domain wedge should be highlighted or circled as a potential need.

Strengths should be highlighted or circled using the same approach. For example if a parent has close friends and extended family, the relationships domain of the community sector should be highlighted or circled as a strength. If a child is healthy and performing well at school, then the learning and development and health segments in the child sector should be highlighted or circled as strengths.

This will present you with a holistic picture of the child/young person/family’s needs, which can help you identify where additional support may be needed. It will help you identify what should happen next, in collaboration with the child, young person or family member.

Examples of a strengths-based approach are provided in Box 4.2.

Box 4.2

EXAMPLES OF A STRENGTHS-BASED APPROACH

Adopting a strengths-based approach means building on a child’s or family’s strengths rather than emphasising their shortfalls. Rather than focusing on problems, a strengths-based approach with families aims to focus on solutions.

An evaluation of South Australia’s Families Empowered to Act Together (FEAT) program, an early intervention program that aims to support families with children aged 5 to 13 years at risk of disengaging from learning identified that the strengths-based approach was central to its overall success.

The FEAT program provides a number of services for children and families such as holiday programs, advocacy, specialised programs (such as anger management for boys and camps), counselling, case management and referrals to special education.

FEAT uses a strengths-based approach which focuses on the role of the family, peers and connections to the broader community in supporting a child to engage with the school and be able to learn. The majority of carers, children and other stakeholders reported that the program had positive outcomes. The success of the strengths-based aspect of the program was recognised in the first recommendation of the evaluation, which recommended that the strengths-based ethos remain a defining characteristic of the FEAT program.

Chapter 5
Professional judgement reference point

The professional judgement reference point of the needs identification mechanism provides you with some example indicators and questions to help you identify the needs of children, young people and their families. These indicators and questions suggest some relevant issues for you to think about when you are considering whether a child/young person or parent/carer may have underlying needs that could require further support.

You may find it helpful to use the professional judgement reference point as the first stage of the needs identification process, to help you verify your initial concern before discussing the issue with the child, young person or family. This is meant as an ‘internal’ exercise, i.e. you would:

- ask yourself some of the overarching questions that have been developed for each domain; and/or
- consider whether any of the example indicators apply (or other indicators of need that you are aware of); and/or
- ask yourself some of the supplementary questions.

Where an indicator of need seems to apply or where the answer to any of the overarching or supplementary questions is ‘no’, you can then take further action. You do so by engaging in a conversation with the child/young person/family by using any of the other components: the ‘wheel’, the conversation prompts and/or the self-assessment questionnaire.

The professional judgement reference point cuts across whole domains, as shown in the example at Figure 5.1. A list of example indicators, overarching and supplementary questions is presented in Table 5.1.
The indicators and questions are intended to provide you with examples of potential needs and the issues that may be relevant to identifying needs. However, these have limitations and are intended only as a guide. In particular:

- the indicators and questions are **not comprehensive** — there will be other issues and needs you should consider which may be relevant, drawing on your professional experience;

- for each indicator there is a **continuum from strength through to significant need** and there are **no distinctive ‘thresholds’** to suggest when the existence of a negative indicator implies a certain level of need that may require action. For example some indicators do not, in isolation, point to an underlying need but may point to needs when considered alongside several other indicators or with contextual information regarding the family’s strengths. You should therefore use your personal and professional judgement and input from the family to determine what ‘needs’ are those requiring attention;
• you are **not expected to consider all indicators and supplementary questions for each individual** – each indicator will not be relevant for all children and an awareness of potential needs in one domain would be sufficient for discussing the issues with the child/young person/family and considering what action should be taken. At that stage you should aim to consider each domain, at least briefly, to provide a holistic view;

• the number of example indicators are not a reflection of the relative importance of different issues or domains, they are based on what practitioners have told us would be helpful.
Table 5.1

INDICATORS AND PROFESSIONAL JUDGEMENT REFERENCE POINT

<table>
<thead>
<tr>
<th>Domain</th>
<th>Child/ family/ community</th>
<th>Example indicators</th>
<th>Overarching questions</th>
<th>Supplementary questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical health</td>
<td>Child</td>
<td>Child health status (self / parental perception)</td>
<td>Is this child (and his/her family) physically healthy?</td>
<td>• Is the child growing and developing? Consider nutrition, immunisation status, any illnesses, dental health, any disability or other specific health problem, including language development.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(under 5s) Very low birthweight (&lt;1,500 grams)</td>
<td></td>
<td>• Is this child’s immediate family healthy? Consider the health of parents/carers and siblings. Does anyone have a disability, illness or other specific health problem?</td>
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<td></td>
<td></td>
<td>Child with special healthcare needs</td>
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<tr>
<td></td>
<td>Family</td>
<td>(under 5s) Immunisation level</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>(under 5s) Infant feeding</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Family member with special healthcare needs</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Parents provide for child’s physical health needs (e.g. appropriate nutrition, rest and medical care)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community</td>
<td>Access to and utilisation of basic health care services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(adolescents) Access to and utilisation of reproductive health services</td>
<td></td>
<td></td>
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<tr>
<td>Mental health and emotional wellbeing</td>
<td>Child</td>
<td>Mental health and psychological well-being</td>
<td>Is this child (and his/her family) emotionally healthy?</td>
<td>• Does the child seem confident and comfortable with parents/carers? Does the child seem calm and peaceful?</td>
</tr>
<tr>
<td></td>
<td>Family</td>
<td>Mental health of family members</td>
<td></td>
<td>• Does this child’s immediate family seem to be coping? Do they appear to enjoy being a family?</td>
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<tr>
<td></td>
<td></td>
<td>Parental history of abuse</td>
<td></td>
<td>• Consider the mental health/emotional wellbeing of parents / carers and siblings. Does anyone have a diagnosed mental health problem or symptoms?</td>
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<tr>
<td></td>
<td></td>
<td>Parent/child attachment (e.g. eye contact, emotional warmth)</td>
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<tr>
<td></td>
<td>Community</td>
<td>Trusted adults</td>
<td></td>
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<tr>
<td>Safety</td>
<td>Child</td>
<td>Sense of safety</td>
<td>Is this child safe?</td>
<td>• How is the child’s safety ensured, demonstrated and sustained? Consider your knowledge of the past and future</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-harming behaviour</td>
<td></td>
<td>• What is known of family discipline practices?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(adolescents) Risk-taking behaviour (e.g. smoking; alcohol and drug use; involvement with police)</td>
<td></td>
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</tr>
</tbody>
</table>

*The conversation prompts have been developed from existing professional tools, guidance and surveys and refined with input from universal service providers based on their professional experience.*
<table>
<thead>
<tr>
<th>Domain</th>
<th>Child/family/community</th>
<th>Example indicators</th>
<th>Overarching questions</th>
<th>Supplementary questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td></td>
<td>Home is a safe place to be</td>
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<tr>
<td></td>
<td></td>
<td>Protection from danger and harm in home</td>
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<td></td>
<td>Previous child protection concerns</td>
<td></td>
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<td></td>
<td></td>
<td>Addictive behaviour in family (alcohol, drugs, gambling)</td>
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<td></td>
<td>Injuries</td>
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<td></td>
<td></td>
<td>Family violence</td>
<td></td>
<td></td>
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<tr>
<td>Community</td>
<td></td>
<td>Safe neighbourhood</td>
<td></td>
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<td>Safe school environment</td>
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<td></td>
<td></td>
<td>Protection from danger and harm in the community</td>
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<tr>
<td></td>
<td></td>
<td>Bullying and victimisation</td>
<td></td>
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<tr>
<td>Material wellbeing</td>
<td>Child</td>
<td>Child feels adequately provided for</td>
<td>Does this child have access to adequate resources?</td>
<td>Does the family have enough money to meet their needs?</td>
</tr>
<tr>
<td>(economic security)</td>
<td>Family</td>
<td>The ability to pay for family essentials</td>
<td></td>
<td>Does the child have sufficient food and appropriate clothing?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parents provide for child’s basic needs (e.g. appropriate clothing, bed, school books)</td>
<td></td>
<td>If the family is struggling, do they know enough ways to access help?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adult/s in paid employment</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Mother’s educational level</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>Household crowding</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Food security</td>
<td></td>
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<tr>
<td></td>
<td>Community</td>
<td>Housing stability and quality</td>
<td></td>
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<td></td>
<td></td>
<td>Access to and utilisation of transport</td>
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<td></td>
<td></td>
<td>Ability to pay for leisure activities</td>
<td></td>
<td></td>
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<tr>
<td>Learning and</td>
<td>Child</td>
<td>Age-appropriate development</td>
<td>Is this child learning and developing?</td>
<td>Does the child have any specific learning needs?</td>
</tr>
<tr>
<td>development</td>
<td>Family</td>
<td>Achievement levels</td>
<td></td>
<td>Consider the child’s educational attainment, attendance and aspirations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Attitude to learning</td>
<td></td>
<td>Does the parent/carer support the child’s learning and development e.g. help with homework; supporting attendance at school?</td>
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<td></td>
<td></td>
<td>Attendance at preschool/school/college</td>
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<td></td>
<td></td>
<td>Family support for educational development</td>
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</tbody>
</table>

The Allen Consulting Group
<table>
<thead>
<tr>
<th>Domain</th>
<th>Child/ family/ community</th>
<th>Example indicators</th>
<th>Overarching questions</th>
<th>Supplementary questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>Parental guidance and boundaries to regulate child's behaviour</td>
<td>Access to and participation in consistent and positive activities, including play, sport and active leisure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationships</td>
<td>Child</td>
<td>Sense of belonging/identity</td>
<td>Does this child and his/her family have healthy relationships?</td>
<td></td>
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<tr>
<td></td>
<td>Family</td>
<td>Stability and warmth of relationships with parents/carers</td>
<td></td>
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<td></td>
<td></td>
<td>Time spent doing things together</td>
<td></td>
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<td></td>
<td></td>
<td>Time spent using electronic media</td>
<td></td>
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<td></td>
<td></td>
<td>Family functioning</td>
<td></td>
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<td></td>
<td></td>
<td>Family stress</td>
<td></td>
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<td></td>
<td></td>
<td>Family involvement with the legal system</td>
<td></td>
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<tr>
<td></td>
<td>Community</td>
<td>Social and friendship networks</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Positive engagement with peers</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Parents involved in helping in school, voluntary work in community; child involved in volunteering</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Family access to and utilisation of universal services</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Family relationships with agencies including schools</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Family integrated into community</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Frequency of change of address</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Rural isolation</td>
<td></td>
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</tbody>
</table>

Source: Allen Consulting Group
Chapter 6

Conversation prompts

Once you have an idea about their concerns and possible needs you should engage the child, young person or family in a conversation. A collaborative approach should be used to identify strengths and needs and possible solutions. This chapter contains conversation prompts (in Table 6.1) to help guide your discussion with children, young people and families and explains how these can be used.

Aim of the conversation prompts

The conversation prompts can help you structure a conversation with children, young people and families. In general, you will rely on your experience and professional judgement but these prompts can be particularly useful for discussing issues with which you are less familiar in your core professional role and to help you phrase questions that might reveal a need if you are unsure how to do so.

Fit between conversation prompts and the wheel and indicators

The prompts are loosely linked to each example indicator and sphere (child/family/community) as illustrated in Figure 6.1. This will help you identify in which areas of a child/young person’s life any identified needs and strengths lie. However, in some cases, the direction of discussion flowing from use of a prompt may be relevant to one of the other indicators and/or sphere.

Figure 6.1

EXAMPLE OF CONVERSATION PROMPTS FOR ENGAGING PARENTS OR CARERS

Using the conversation prompts

The conversation prompts are a menu of open-ended questions you could ask to encourage conversation. They are not a ‘script’ for needs identification, in particular:
you will only need to select some of these questions as there are many more prompts than you would need to use — you should select questions which help you identify both strengths and needs, in keeping with a strengths-based approach;

you will need to change the order of the questions to suit the flow of the conversation — they are currently arranged according to the domains and indicators of need; and

you will need to tailor questions according to the age, cultural and language backgrounds of the children or young people in question and the specific issues that arise — the prompts are not comprehensive and do not cover every issue that could be relevant (see Box 6.1).

Box 6.1

USING YOUR EXPERIENCE AND PROFESSIONAL JUDGEMENT

It is important for you to use your experience and professional judgement to select and tailor prompts for individual circumstances. In particular:

• there are prompts which are suitable for discussion with an adult (the parent or carer) and prompts suitable for discussion with a child or young person, however they are not explicitly tailored to children of different ages
• a few prompts are only suitable for infants or adolescents and these have been identified as such; the remaining prompts may be suitable for children of a variety of ages (although some will not be suitable for very young children) but they will need to be tailored for the age of the child and their level of development;
• the prompts are not tailored to children/young people of different cultures, ethnic groups or language backgrounds — you should use your expertise to adapt your conversation to reflect the differing experiences and needs of these groups; and
• whilst the prompts can aid your thinking regarding the type and style of questions that may be suitable, you should use your experience and professional judgement to determine how to conduct a discussion with a child/young person/family;

The number of questions for each domain is a reflection of a range of potential issues that may be relevant but is in no way a reflection of the relative importance of each domain.

A small number of ‘core’ conversation prompts are highlighted as they are quite general and open-ended and may provide a useful starting point for a discussion about each domain.

You should select the most appropriate follow-up questions according to the answers given — this may include asking some further open questions such as:

• ‘tell me more about that?’;
• ‘why is that?’; or
• ‘how is that going?’
Where responses indicate aspects of a child’s or family’s life that are going well, or the family has already developed good coping strategies for particular situations, it is important to affirm these and offer praise. If there are specific issues of concern, the ‘core’ conversation prompts will often be a good way of opening the conversation before moving to the specific issues — for example if you are concerned about bullying, you may want to start by asking more general questions like ‘How are things going at school?’; ‘What’s good about school?’; ‘What don’t you like about school?’.
### Table 6.1
**PROMPTS FOR DISCUSSION WITH CHILD/FAMILY**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Child family/community</th>
<th>Indicators</th>
<th>Conversation prompts for the parent/carer (core prompts in bold)</th>
<th>Conversation prompts for children and young people (core prompts in bold)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical health</td>
<td><strong>Child</strong></td>
<td>Child health status (self/parental perception)</td>
<td>• How is your child’s health in general?</td>
<td>• In general, how would you describe your health?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• What things does your child do to keep healthy?</td>
<td>• What things do you do to keep healthy?</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• When was the last time your child saw a doctor?</td>
<td>• Are you feeling well today? Do you usually feel well?</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Has your baby/child had any illnesses?</td>
<td>• Do you do any physical or outdoor activities like swimming, running or team sports to you do? How often?</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• How much exercise does your child get in a typical week?</td>
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<td></td>
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<td></td>
<td>• Do you have any concerns about your child’s health?</td>
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</tr>
<tr>
<td>Very low birthweight</td>
<td>(For under 5s)</td>
<td>• Was there any concern about your child’s weight at birth? Do you remember what he/she weighed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(&lt;1,500 grams or 3.3lbs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child with special healthcare needs</td>
<td>(For under 5s)</td>
<td>• Does your child have any special healthcare needs?</td>
<td></td>
<td>• Do you see any doctors or nurses on a regular basis?</td>
</tr>
<tr>
<td>Family</td>
<td><strong>Immunisation level</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant feeding</td>
<td>(For under 5s)</td>
<td>• What immunisations has your baby/child had?</td>
<td>• Do you know about routine health checks for children?</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>What health checks has your baby/child had? Do you use the baby/child health record (the “blue book”)?</td>
<td></td>
</tr>
<tr>
<td>Family member with special healthcare needs</td>
<td>(For under 5s)</td>
<td>• How are you feeding your baby? Tell me about your baby’s feeding patterns. Do you think your baby is feeding ok?</td>
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<tr>
<td></td>
<td></td>
<td>• In general, how is your health and the health of other members of your family (e.g. other parent, siblings)?</td>
<td>• In general, how healthy are other people in your family (such as your parents and any brothers or sisters)?</td>
<td></td>
</tr>
<tr>
<td>Domain</td>
<td>Child family/community</td>
<td>Indicators</td>
<td>Conversation prompts for the parent/carer (core prompts in bold)</td>
<td>Conversation prompts for children and young people (core prompts in bold)</td>
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</tbody>
</table>
|                                |                        | Parents provide for child’s physical health needs (e.g., appropriate nutrition, rest and medical care) | • Tell me about your family’s eating habits. Do you have any worries about your child’s eating?  
• Do your children have good appetites?  
• Tell me about your child’s sleeping habits. Does he/she have a set bedtime and wake up time? | • Do you help to look after anyone at home (such as a sick parent or a disabled brother or sister)?  
• Is anyone in the family in hospital or waiting for an operation?  
• Do you feel that you eat well in general?  
• Describe the sorts of food you eat most weeks.  
• Is your appetite OK or is it ever a problem? |
| Community                      |                        | Access to and utilisation of basic health care services                     | • When did your child last visit the dentist?  
• Is there anything that stands in the way of you using health services when you need them? | • When did you last visit the dentist?  
• Is there anything that stands in the way of you using health services when you need them? (For adolescents)  
• Are you in a sexual relationship? Do you know about sexual health/ have access to appropriate birth control? |
|                                |                        | Access to and utilisation of reproductive health services                  | • Is your child mostly full of energy?  
• Has there been a change in energy levels in the past month? Why do you think this is so?  
• How easy do you think your child finds it to sit still and not fidget at school/home? Can you give me some examples to explain your answer?  
• Does your child seemed worried about things? How big a problem is this?  
• Do you have any worries about any aspects of your baby or child’s behaviour?  
• During a typical week, how much sleep does your child have per night?  
• How would you describe the quality of your child’s sleep?  
• What does your child do for relaxation or fun? Has this changed over the past few weeks? | • Are you mostly happy (or satisfied with your life)? What about during the last month?  
• How many times have you felt down, depressed or sad in the past month? Is this something you would like help with?  
• Do you think you are an energetic person? Are you often bursting with energy?  
• Do you mostly feel in control of your life?  
• Do you often feel worried about things? What about during the past month?  
• Can you find things to do that interest you and give you pleasure?  
• Do you find it difficult to control what or how much you eat?  
• How would you describe your eating habits? Is what you eat an issue with your family? |
<table>
<thead>
<tr>
<th>Domain</th>
<th>Child family/community</th>
<th>Indicators</th>
<th>Conversation prompts for the parent/carer (core prompts in bold)</th>
<th>Conversation prompts for children and young people (core prompts in bold)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family</strong></td>
<td></td>
<td>Mental health of family members</td>
<td>• How happy (or content) would you say you are overall?</td>
<td>• How do you know when you’re feeling upset?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Do you mostly feel you are in control of your life? Can you explain why you feel that way?</td>
<td>• Has there been a big change in your life that has been stressful?</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• In general, how is the health of other members of your family (e.g. other parent, siblings)? Are they mostly happy (or content)?</td>
<td>• How well do you sleep? Has sleeping been a problem recently? Would you like help?</td>
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<td></td>
<td></td>
<td></td>
<td>• Is there any family history of mental health problems such as depression or anxiety?</td>
<td>• Do you sometimes feel breathless of like your heart is beating faster than usual? Do you ever feel anxious?</td>
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<tr>
<td></td>
<td></td>
<td>Parental history of abuse</td>
<td>• Tell me about your experiences as a child – what was family life like as you were growing up?</td>
<td>• Taking all things together, how happy (or satisfied) would you say your mum or dad or carer is? How do you know when they are unhappy?</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• When you (or siblings) did something that was considered wrong by your parents, how were you disciplined?</td>
<td>• Are other people you live with (such as your brothers and sisters) usually happy? What things make them sad? How do they show they are sad?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parent/child attachment (e.g. eye contact, emotional warmth)</td>
<td>• What do you and your child do together for fun?</td>
<td>• Do you like cuddles/hugs? Do you think your mum/dad/carer give you enough cuddles?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• How do you and your child spend time together?</td>
<td>• If you do something well, is there someone who would be proud and notice what you had done?</td>
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<td></td>
<td></td>
<td></td>
<td>• What do you think is the best part of being a parent? What things do you find hardest to deal with?</td>
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<td>• In a typical day how often do you hold/cuddle/talk to your baby or child?</td>
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<td>• (For under 5s) Do you like to give your baby/child a cuddle? Does your baby enjoy a cuddle? How often do cuddles happen?</td>
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<tr>
<td>Domain</td>
<td>Child family/community</td>
<td>Indicators</td>
<td>Conversation prompts for the parent/carer (core prompts in bold)</td>
<td>Conversation prompts for children and young people (core prompts in bold)</td>
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</tbody>
</table>
| Community | Trusted adults |  | • Tell me about the people (family and friends) who are important to your child?  
• How often are these people seen and do they live nearby? | • Who would you go to if you needed help or support?  
• How many adults are there in your life who you feel you can trust? |
| Safety | Child | Sense of safety  
Self-harming behaviour  
Risk-taking behaviour (e.g. early sexual activity; smoking; alcohol and drug use; involvement with the police) | • Is your child happy to spend a lot of time at home?  
• To your knowledge, has your child ever deliberately hurt him/herself?  
• How would you describe your child’s behaviour in general in the past month?  
• Has there been a change in your child’s behaviour in the past month? Why do you think this is so?  
• Have you discussed these changes or concerns with another adult/your child? | • Do you usually feel safe? What things make you feel unsafe?  
• Have you ever deliberately hurt yourself?  
• How would you describe your behaviour in general in the past month?  
• If you do something wrong, are you likely to get into trouble? Tell me what happened the last time?  
• [For adolescents] Have you ever experimented with drugs, cigarettes or alcohol? |
| Family | Home is a safe place to be  
Protection from danger and harm in home |  | • Do you feel able to make sure your child is safe?  
• Have you ever felt afraid, for yourself or your child, at home? Why was that?  
• What do you think needs to change for you, or your child, to feel safe in your home?  
• Do you monitor what your child looks at on the internet? | • Do you feel safe at home?  
• Have you ever felt afraid at home?  
• How much of the time do you feel uncomfortable/uneasy at home? What things make you feel that way?  
• Do you use the internet at home? Does anyone tell you what you can and can’t view?  
• [For adolescents] Have you ever seen a social worker, youth worker or care and protection officer? Did you find it helpful?  
• Is there anything about the place you live or the people you live with that makes you feel unsafe or uncomfortable? |
| Family | Addictive behaviour in family (alcohol, drugs, gambling) |  | • Are there any issues in the family or behaviours or habits of family members that could make your child stressed or uncomfortable?  
• Do these issues make it difficult for you to keep your child safe?  
• Do you and other family members drink alcohol? Tell me about you / their drinking habits. |  |
## Domain: Child family/community

### Indicators

<table>
<thead>
<tr>
<th>Child indicator</th>
<th>Conversation prompts for the parent/carer (core prompts in bold)</th>
<th>Conversation prompts for children and young people (core prompts in bold)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Injuries</strong></td>
<td>- Have you ever had to take your child to the hospital for an accident or injury in the home? Can you tell me about what had happened?</td>
<td>- Have you ever had an accident or injury at home and had to go to the emergency room of a hospital or medical centre?</td>
</tr>
<tr>
<td><strong>Family violence</strong></td>
<td>- What does your family do for fun and relaxation together?</td>
<td>- Do you enjoy spending time with your family?</td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td>- How do you and your family/partner resolve disagreements?</td>
<td>- Has anybody at home hurt you?</td>
</tr>
<tr>
<td><strong>Bullying and victimisation</strong></td>
<td>- Do you feel safe to voice your opinion/partner resolve disagreements?</td>
<td>- Have you ever been made to feel stupid at home?</td>
</tr>
<tr>
<td><strong>Protection from danger and harm in the community</strong></td>
<td>- Has anybody at home hurt you – by physically hurting you or “putting you down”?</td>
<td>- Do people in your family often insult or shout at one another?</td>
</tr>
</tbody>
</table>

### Child feelings adequately provided for

- Child feels adequately provided for
  - Do you think that your family has enough money?
  - Do you think that your family gives you enough food and clothes?
  - Do you ever go hungry?
<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicators</th>
<th>Conversation prompts for the parent/carer (core prompts in bold)</th>
<th>Conversation prompts for children and young people (core prompts in bold)</th>
</tr>
</thead>
</table>
| **Family**              | The ability to pay for family essentials                                     | • *Is it a struggle to meet your family's needs?*  
• How easy or difficult is it to manage on your family’s income?  
• Does your family work out a monthly budget?  
• Are you able to replace or repair any worn out furniture?  
• Are you able to replace or repair major electrical goods such as a fridge or washing machine when broken? | • *Do you think your family worries about money or about paying the bills?*  
• Is there enough money to meet your family’s needs?  
• If things at home are broken, do they get fixed or replaced?  
• *What do you like best about your home?*  
• *[observation e.g. lack of appropriate clothing or school books]* |
|                         | Parents provide for child’s basic needs (e.g. appropriate clothing, bed, school books) | • How easy or difficult is it for your family to pay for schooling and books?  
• If your child has grown out of their shoes and/or clothes, how easy or difficult is it for your family to pay for new items?  
• *[observation e.g. lack of appropriate clothing or school books]* |                                                                                                                                  |
|                         | Adults in paid employment                                                    | • Which adults in your home are in paid employment? Do they work full time, part time or on a temporary basis?                     | • At home, who is in a paid job and what do they do?                                                                                                                                               |
|                         | Mother’s educational level                                                   | • How old were you when you left school?  
• Did you do any further studying after school?                                                                                       |                                                                                                                                  |
|                         | Household crowding                                                          | • Do you feel that your house is big enough for your family’s needs? Why do you feel that?                                     | • Do you feel that your house is big enough for your family’s needs? Why do you feel that?                                                                                                         |
|                         | Food security                                                               | • Are you able to buy enough food to satisfy everyone’s hunger?  
• Have you ever run out of food and not been able to afford to buy more?                                                            |                                                                                                                                  |
| **Community**           | Housing stability and quality                                                | • How easy or difficult is it for you to meet your mortgage repayments/fortnightly rent?  
• Is there anything you would like to change about your home to make it a better place to live?                                     | • What would make your home a better place to live?                                                                                                                                             |
|                         | Access to and utilisation of transport                                        | • Do you find it easy to get around your local area? If not, what difficulties do you have (e.g. lack of transport, cost of transport)? | • Do you find it easy to get around your local area? If not, what difficulties do you have (e.g. lack of transport, cost of transport)? |

**Notes:**
- Core prompts are in bold.
- Observations are enclosed in square brackets.
<table>
<thead>
<tr>
<th>Domain</th>
<th>Child family/community</th>
<th>Indicators</th>
<th>Conversation prompts for the parent/carer (core prompts in bold)</th>
<th>Conversation prompts for children and young people (core prompts in bold)</th>
</tr>
</thead>
</table>
| **Ability to pay for leisure activities** |                        | • How easy or difficult is it for you to pay for extra activities for your child e.g. swimming, sports equipment, cinema trips?  
• How easy or difficult is it for you to pay for your child to go on school trips?  
• Does your family get special time together e.g. trips to the movies or bowling? How often do you manage to do these activities? | • Does your family ever go out for special time together e.g. trips to the movies or bowling? |
| **Learning and development**    | **Child**              | **Age-appropriate development**                | • Does your child have any speech or language difficulties?  
• Does your child have any special learning needs? | • Do you like / enjoy school?  
• What is the best thing about school, preschool or college?  
• What’s your best subject? / What’s your favourite thing to learn at school?  
• What do you want to do in the future / when you grow up?  
• What do you do if you find something hard to do at school? |
|                                 |                        | **Attitude to learning**                       | • Do you like / enjoy school?  
• What is the best thing about school, preschool or college?  
• What’s your best subject? / What’s your favourite thing to learn at school?  
• What do you want to do in the future / when you grow up?  
• What do you do if you find something hard to do at school? | • How well do you think you are doing at school/college/with your learning? Do you need any extra help?  
• What are you good at doing?  
• How do you manage with reading and writing compared to your class? What about maths? How are you managing there?  
• What’s your best subject? |
| **Achievement levels**          |                        | • How well is your child doing at preschool/school/college?  
• Does your child need any extra help with learning to make sure you do he/she does his/her best? | • How well do you think you are doing at school/college/with your learning? Do you need any extra help?  
• What are you good at doing?  
• How do you manage with reading and writing compared to your class? What about maths? How are you managing there?  
• What’s your best subject? | • Over the past 12 months, has your child missed preschool/school/college? (If yes) How many days did your child miss?  
• What were the reasons for your child missing these days of preschool/school/college? |
| **Family**                      |                        | **Attendance at preschool/school/college**     | • Over the past 12 months, has your child missed preschool/school/college? (If yes) How many days did your child miss?  
• What were the reasons for your child missing these days of preschool/school/college? | • Do you miss many days (or classes) of school/ preschool/college? How many days/classes have you missed this month?  
• How many different schools have you attended? |
<table>
<thead>
<tr>
<th>Domain</th>
<th>Child family/community</th>
<th>Indicators</th>
<th>Conversation prompts for the parent/carer (core prompts in bold)</th>
<th>Conversation prompts for children and young people (core prompts in bold)</th>
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<tbody>
<tr>
<td>Family support for educational development</td>
<td>How many different schools has your child attended?</td>
<td>Tell me about how easy or difficult it is for your child to complete their homework. Why do you think your child finds it easy/difficult?</td>
<td>Do you have someone to help you with your schoolwork?</td>
<td>Does anyone read to you apart from at school?</td>
</tr>
<tr>
<td>Parental guidance and boundaries to regulate child’s behaviour</td>
<td>Do you help your child with their schoolwork?</td>
<td>Do you read to your child? Does anyone else at home read to your child?</td>
<td>Do you have a quiet place where you can do your schoolwork?</td>
<td>Do you get into trouble much? Are you often angry for no reason?</td>
</tr>
<tr>
<td>Community</td>
<td>How do you guide your child’s behaviour?</td>
<td>What do you find most difficult with their behaviour at present?</td>
<td>What activities does your child do for relaxation or fun?</td>
<td>What activities do you like doing best?</td>
</tr>
<tr>
<td>Access to and regular participation in consistent and positive activities, including sport and active leisure</td>
<td>What does your child do for relaxation or fun?</td>
<td>Does your child belong to any groups or clubs outside school?</td>
<td>Do you belong to any groups or clubs outside school?</td>
<td>Do you do any physical/outdoor activities like walking, swimming, riding your bike, running or playing?</td>
</tr>
<tr>
<td></td>
<td>What activities does your child like doing best?</td>
<td>Does your child do any physical/outdoor activities like walking, swimming, running or playing?</td>
<td>Do you do any physical/outdoor activities like walking, swimming, riding your bike, running or playing?</td>
<td>Do you find it easy to get to places where you can play/play sport?</td>
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<tr>
<td></td>
<td>How often does your child participate in these activities?</td>
<td>Is there anything that prevents your child participating (or participating more frequently) in leisure/sporting activities?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationships</td>
<td>Child</td>
<td>Sense of belonging / identity</td>
<td>Do you feel like you fit in at school? / How many days last week did you feel as though you fitted in at school?</td>
<td>Do you feel like you fit in at school? / How many days last week did you feel as though you fitted in at school?</td>
</tr>
<tr>
<td></td>
<td>Family</td>
<td>Stability and warmth of relationships with parents/carers</td>
<td>Do you think that the people in your home are good at supporting each other?</td>
<td>Do mostly feel good about yourself?</td>
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<tr>
<td></td>
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<td></td>
<td>What things do you do together as a family?</td>
<td>Tell me one thing about yourself that you think is special</td>
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<td>What is special about your family?</td>
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<td>If you had to describe the quality of your family relationships, what would you say?</td>
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<tr>
<td>Domain</td>
<td>Child family/community</td>
<td>Indicators</td>
<td>Conversation prompts for the parent/carer (core prompts in bold)</td>
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<tr>
<td>Time spent using electronic media</td>
<td></td>
<td>• In a typical week, how much time do you get to spend together as a family? How is this time spent?</td>
<td>• Do you sleep away from home often? Where do you stay when you do?</td>
<td>• How much time did you spend last week watching TV or playing on a computer?</td>
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<tr>
<td></td>
<td></td>
<td>• How much time did your child spend last week watching TV or playing on a computer?</td>
<td>• Do you find it difficult to monitor your child’s television viewing or electronics playing?</td>
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<tr>
<td>Family functioning</td>
<td></td>
<td>• What are your family’s strengths?</td>
<td>• What is special about your family? / What are your family’s strengths?</td>
<td>• Do you eat many meals with your parents?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• In a typical week, how many times does your family sit down for a meal together?</td>
<td>• Does your family have rules like when to go to bed, how often you have to help with chores, when to be quiet or when you can go out?</td>
<td>• Does your family have rules like when to go to bed, how often you have to help with chores, when to be quiet or when you can go out?</td>
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<td></td>
<td></td>
<td>• What is important to your family regarding children’s behaviour? What is acceptable and not acceptable?</td>
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<tr>
<td>Family stress</td>
<td></td>
<td>• All families have times when there is more stress than usual. Has your family had any of these times recently (for example over the last month)?</td>
<td>• Does anyone in your family work away from home (in another town) or at night, so that you don’t see them very often?</td>
<td>• Do you feel that there is a lot of stress in your family?</td>
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<tr>
<td></td>
<td></td>
<td>• Does anyone in your family work away from home (in another town) or at night or work a lot of overtime, so that you don’t see them very often?</td>
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<tr>
<td>Family involvement with the legal system</td>
<td></td>
<td>• Have you or anyone in your family had dealings with the police or legal system? Can you tell me about that?</td>
<td>• Has anyone in your family had to go to court for any reason? Can you tell me about why that was?</td>
<td>• What people are important to you apart from your family at home? Do you think they would be able to help you if you needed help?</td>
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<td></td>
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<td></td>
<td>• Have the police come to see anyone in your family? Do you know why this was?</td>
<td>• Do your parents/carers have someone to help them if they need help?</td>
</tr>
<tr>
<td>Community</td>
<td>Social and friendship networks</td>
<td>• Do you feel you can get support from outside your family when you need it?</td>
<td>• What people are important to you apart from your family at home? Do you think they would be able to help you if you needed help?</td>
<td>• Do you see your friends when you are not at school/pre-school/college?</td>
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<td>• Tell me about the people (family and friends) who are important to your family. How often do you see these people? Do they live nearby?</td>
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<td>• Is there someone that you know and trust that you can turn to for help if you need it?</td>
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<td></td>
<td>• Does your child see friends outside school/pre-school/college?</td>
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<td></td>
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<td>• Do you think your baby is learning to be interested in other</td>
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<td>Domain</td>
<td>Child family/community</td>
<td>Indicators</td>
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<td>people, or does he/she find them scary?</td>
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<td>• How well do you think your child gets along with his/her friends? How well does your child get along with other adults?</td>
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<tr>
<td>Positive engagement with peers</td>
<td></td>
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<td>• What sort of things does your child do with his/her friends?</td>
<td>• What sort of things do you do with your friends?</td>
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<td></td>
<td>• How often does your child get to spend time with them?</td>
<td>• Who do you spend most of your time with?</td>
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<td>• Do you have a best friend? Why do you think this person is your best friend?</td>
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<td>• (For adolescents) Do you have a girlfriend/boyfriend? How would you describe your relationship with your girlfriend/boyfriend?</td>
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<td>• Can you tell me about a special time when you remember helping somebody?</td>
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<td>• Do you feel comfortable speaking to your teachers if you have a problem or a worry?</td>
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<td>Relationships with child’s school; voluntary work in community</td>
<td></td>
<td></td>
<td>Are you involved in any voluntary work in your community?</td>
<td>• What local facilities do you use (e.g., sports, play and leisure centres, parks, libraries etc)?</td>
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<td></td>
<td></td>
<td></td>
<td>• Do you help out at your child’s school?</td>
<td>• Are there facilities that you would like to use that you can’t use for some reason?</td>
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<td></td>
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<td>• When was the last time you had contact with your child’s school? What was that about?</td>
<td>• Are there facilities or places (like parks) in your neighbourhood that your family specially likes using/going to?</td>
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<td></td>
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<td>• When was the last time you spoke to your child’s teacher? Was that a positive conversation?</td>
<td>• What things in your neighbourhood do you use (e.g., sports, play and leisure centres, parks, libraries etc)?</td>
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<td></td>
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<td></td>
<td>• How would you describe your relationship with your child’s school/teacher?</td>
<td>• Are there things in your neighbourhood that you would like to use that you can’t use for some reason?</td>
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<td></td>
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<td></td>
<td>• Do you feel able to approach staff at your child’s preschool/school about any concerns or difficulties?</td>
<td>• Have you contacted support services for you or your child in the past 6/12 months?</td>
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<tr>
<td>Family access to and utilisation of universal services</td>
<td></td>
<td></td>
<td>Are there facilities or places (like parks) in your neighbourhood that your family specially likes using/going to?</td>
<td>• What local facilities do you use (e.g., sports, play and leisure centres, parks, libraries etc)?</td>
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<td></td>
<td>• What things in your neighbourhood do you use (e.g., sports, play and leisure centres, parks, libraries etc)?</td>
<td>• Are there facilities that you would like to use that you can’t use for some reason?</td>
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<tr>
<td></td>
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<td></td>
<td>• Are there things in your neighbourhood that you would like to use that you can’t use for some reason?</td>
<td>• Have you contacted support services for you or your child in the past 6/12 months?</td>
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<tr>
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<td></td>
<td>• Do you feel a sense of belonging to your community? Why is that?</td>
<td>• Are there people in your neighbourhood or community who could help your parents/carers if they needed help?</td>
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<td></td>
<td></td>
<td></td>
<td>• Are there people in your neighbourhood or community that you could turn to for help if you needed it?</td>
<td>• Do you or your family join in local activities or events?</td>
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<td></td>
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<td></td>
<td>• Do you have the opportunity to participate in cultural life and community activities in your local area?</td>
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<td></td>
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<td></td>
<td>• Do you go to any organisations or services for support or advice (e.g. churches or religious groups; community advice services)?</td>
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<td></td>
<td></td>
<td></td>
<td>• How easy is it for you to get to know about what is happening in your local community?</td>
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<tr>
<td>Family integrated into community</td>
<td></td>
<td></td>
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<tr>
<td>Frequency of change of address</td>
<td></td>
<td></td>
<td>• How long have you lived where you do now?</td>
<td>• How long have you lived where you do now?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Have you moved in the past year? How many times have you moved?</td>
<td>• Have you moved in the past year? How many times have you moved?</td>
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<tr>
<td>Rural isolation</td>
<td></td>
<td></td>
<td>• What is it like living where you live? What are the positive aspects? What are the challenges?</td>
<td>• What is it like living where you live?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• How easy or difficult is it for your family to access local facilities and services? What are the barriers?</td>
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Chapter 7
Self-assessment questionnaire

What is the self-assessment questionnaire

The self-assessment questionnaire is for children/young people to complete by themselves, or with an adult (parent or practitioner). The questionnaire takes between 5 and 10 minutes to complete and comprises a front introductory section with some background information and guidance for completing the questionnaire. The questions cover the six wellbeing domains that correspond with the six sectors of the wheel.

There are between 4 and 14 questions per section and each section concludes in the same manner, which is to ask the respondent to make an overall assessment for the section. The overall physical health question is provided as example in Figure 7.1.

Figure 7.1
PHYSICAL HEALTH CONCLUDING QUESTION

CONSIDERING YOUR ANSWERS TO THE QUESTIONS IN THIS SECTION, HOW HEALTHY ARE YOU OVERALL?
(mark an ‘X’ on the scale to show where you think you are)

Source: Allen Consulting Group.

Together, the questions in each section assist to provide an indication of whether there may be needs in one area. Generally speaking, the answer to one question in isolation will not provide a complete picture of the child/young person’s situation in the specified sector. That is, one ‘negative’ answer does not necessarily indicate a need but will need to be considered in a broader context.

The self-assessment questionnaire forms one way in which you can engage the child/young person/family to identify needs and strengths. It should be used as basis for a conversation about potential needs and, as such, can be used as an alternative to the conversation prompts. The questionnaire is located in Appendix A.
How to use the self-assessment questionnaire

The questionnaire is suitable for children and young people aged 12 years and over. You can invite the child/young person to complete the questionnaire or they might self-select to do so (for example, having seen it online). The important thing to consider is that the questionnaire is a tool for stimulating discussion — it is not a result in itself. Having the child/young person hand the survey back to you may or may not be an option. While some children/young people will be comfortable sharing their answers others may not be, feeling that their answers are private, or sharing only select answers.

Whether or not you are returned the answered questionnaire, it will be important that you engage in a discussion with the child/young person about the strengths and needs identified and potential next steps. Even if you do not receive the answers directly, the questionnaire may have encouraged the child/young person to delve more deeply into aspects of their lives about which they might have some concerns, making it easier for them to articulate where the issues may lie.

You may like to use the information you have gathered from the questionnaire to fill out a ‘wheel’ by circling strengths and needs. This will indicate whether the child/young person’s needs lie mainly in one sphere, or domain, and it may point to where the best path ahead lies.

In some instances, the questionnaire may not be the best way to start a conversation about identifying needs. For example, a child may be too young, or may indicate that they do not want to fill out a questionnaire. If this is the case, using the other components of the needs identification mechanism, such as the conversation prompts, may be more appropriate.

Expectations and obligations for practitioners

Prior to engaging in a conversation about needs, you should inform the child/young person that while, generally speaking, answers will be kept confidential and consent will be sought before information is passed on, in some instances this may not be possible. Your conversation may give rise to issues in a child’s/young person’s life that are required to be reported to a statutory body and children/young people need to be made aware of this possibility.

The questions within the safety domain in particular may lend themselves to this type of consequence if answered in particular ways. For example, if a child/young person were to indicate that they feel afraid at home all of the time (in answer to question C7) your conversation may lead to the child telling you of physical abuse perpetrated by an adult on themselves or their siblings. This issue would need to be referred to the relevant child protection agency.

5 Online access (e.g. url) to be announced.
Chapter 8
Information sharing and referral

The concept of the Common Approach is based on the principle of shared responsibility for the safety and wellbeing of children and young people among all relevant universal services. At the same time, it involves, and is of relevance to, many other services across the services spectrum (e.g. targeted services, other community support). The Common Approach seeks to promote the use of a common language and greater collaboration across and between service sectors.

About the information sharing and referral guidance

This chapter attempts to set out the basic steps for optimal information sharing and referral, without going into the detail that might be required in specific contexts. Due to differences across and within jurisdictions and in the absence of any one comprehensive national approach, it is simply not possible to reflect all relevant legislative provisions and professional approaches, standards and guidelines.

Your organisation or profession is likely to have existing protocols, guidelines and processes for information sharing and referral, as well as links to local service databases. If this is the case, it would be helpful for you to consider whether existing practices could be adapted to the Common Approach to encourage lateral thinking and responsiveness to underlying needs that do not relate directly to one particular discipline.

This section aims to provide you with some general guidance on the ‘next steps’ you could take when you have identified that a child, young person or family member has critical unmet needs which may require additional support, which would not normally be covered by the service you/your organisation offers. It covers:

- how to identify what should happen next, including possible referral pathways;
- optimal referral processes; and
- good practice in sharing information, including processes for obtaining the consent of the child, young person or family member to share information.

Identifying what to do next

When you have identified that a child, young person or parent/carer may need additional support that is outside the scope of your usual professional practice, there are three initial steps:

- **discuss the issues you have identified** with the child, young person or family member — highlight and praise their strengths, as well as explaining your concerns;
- **seek their views** on where they consider they might need assistance; and
- **ascertain** whether they wish to **take steps** toward addressing these issues.
Emphasise the positive aspects of the child’s and family’s life; affirm their strengths and capabilities and provide reassurance that they are being offered support, not criticism. Be specific about the concerns you have, explaining why you think this, based on what you know of their circumstances and what they have told you. This will help ensure that the child, young person or parent/carer understands the issues and will also help you to be sure you are providing the most appropriate information and advice regarding further support options.

**Response pathways**

To respond to the underlying needs, it is recommended that you consider and explore a range of pathways for support. Your starting point is identifying actions the child and family can take on their own behalf and then informal supports before considering a formal response from your own service or an external referral. The following are recommended actions and pathways, in sequence:

- action the **child and family** could take on their own behalf to respond to the needs identified, drawing on the strengths in their life;
- the support that is available from the **child’s extended family** — for the child and/or the parent or carer;
- informal support that is available from the **family’s neighbourhood or in the local community** — for example through close friends, a church, or community groups);
- the additional support you could offer the child or family;
- the additional support and services **your organisation or profession** could offer the child or family — for example, as a teacher you may want to refer a child to the school counsellor or to a colleague who is better placed to provide pastoral support;
- **additional, including specialist, services** to which you could refer the child, young person and/or family — these may include other universal services; targeted services; and other community support. Resources to assist you identify these services, and appropriate contacts within them, could include local service directories, helplines and support network coordination points such as the local council.

Some suggestions for encouraging the child or family to consider how they might tap into existing informal supports are provided in Box 8.1.
Box 8.1

HOW CAN I ENABLE THE CHILD AND FAMILY TO TAKE ACTION AND SEEK INFORMAL SUPPORT?

Encourage parents to:

• talk with the child about the needs identified and listen to (and reflect back) the child’s perspective;
• seek and accept support for themselves, one step at a time;
• seek support from a partner, other family members, friends or specific service providers to understand and respond to the needs identified; and
• seek information and advice about their child’s (and their own) strengths and needs from other practitioners with whom they come into contact (for example in relation to the child’s developmental and/or educational progress, relationships with his or her peers and other adults and involvement in school or community activities).

Encourage children to:

• talk to a parent or another trusted family member about identified needs and feelings or concerns if appropriate;
• think about which of their friends are most likely to be a source of support; and
• feel confident about participating in activities they enjoy, including physical activities such as sports or dancing.

Source: Adapted from the Victorian Child Development and Trauma Guide, Department of Human Services, Melbourne 2007

Identifying the appropriate response

To identify which is the most appropriate support service or action to take you should consider:

• the views of the child, young person or family member on the kind of support they would find helpful;
• the sectors of the ‘wheel’ in which the strengths and underlying needs of the child, young person or family member lie (see Box 8.2); and
• the services that are available in your local area — you may already have access to local, regional or state databases or specialist services available in your area. These will vary depending on your jurisdiction. In the absence of a shared national universal referral database, you might want to consult your local council’s website as many of them have a community referral directory on their website. Examples for online directories and support websites include:
  - Australian General Practice Network programs, network directory and member services;
  - State and Territory Councils of Social Service resource directories;
  - Family Relationships Australia resource directory;
  - Australian Guidance and Counselling Association programs, research and resources;
  - Beyond Blue information for parents and teachers; and
  - Reach Out, an information website for young people around mental health and wellbeing, safety and other issues that has information about how to get help from services.
Your own professional judgement will be important for ensuring that realistic options are presented. If services/supports are available in your region, are there waiting lists, cost or access issues that need to be clarified? If the preferred service does not exist in your region, could alternative pathways of support be considered, or is referral to a service in another town feasible, affordable and practical?

The aim is to reach a joint decision with the child, young person or family member about the actions that will be taken to address underlying needs, including any referrals to other support services. In reaching a decision, you may find it helpful to outline the expected outcomes for the family that could result from the action or proposed referral and what the family could expect to happen next. The whole process is voluntary, and governed by strict confidentiality ethics (see section on ‘sharing information’ and ‘informed consent’).

Box 8.2

USING THE ‘WHEEL’ TO IDENTIFY THE APPROPRIATE RESPONSE

The ‘wheel’, which is at the heart of the needs identification mechanism, is a useful aid for identifying appropriate support, whether that is by enabling the family to take action or accessing a more formal referral pathway. You should consider the sectors in which strengths and needs have been identified and consider the balance between child/young person, family and community factors.

In keeping with a strengths-based approach you should consider if the identified strengths may point to informal supports that can be utilised, for example:

- Noting strengths in the child sphere may help the parent feel more confident about addressing a particular concern – e.g. building on the child’s enjoyment of learning in order to work through concerns about certain aspects of his/her physical or mental health;

- Strengths in the family sphere may suggest that underlying needs can be addressed within the family, perhaps accompanied by some parental or family support services; and

- Strengths in the community sphere suggest that informal community supports (including friends or neighbours) can be utilised.

Building upon the strengths identified may be particularly important where no formal support services are available or immediately accessible.

Tips about how to encourage the child or family to consider taking action themselves to tap into informal support options are provided in Box 8.1.

The following examples are provided as a general rule for accessing support where it becomes apparent that more formal or specialised services are required:

- All the needs are in one domain: This may indicate the appropriate service for referral, e.g. where all needs are in ‘physical health’, referral is made to a GP or other health service; where all needs are in ‘learning and development’, referral can be made to an educational support or remedial teaching program, or a special needs pre-school or school teacher or child care worker;

- Needs are mainly identified in the child sphere: In such cases appropriate referrals may be to children’s services e.g. school, maternal and child health nurse, paediatrician;

- Needs are mainly identified in the family sphere: In these cases, it may be appropriate to refer the parent(s) to services targeting adults e.g. for parenting support, financial counselling, drug and alcohol dependence, etc.;

- Needs are mainly in the community sphere: In this case, it may be appropriate to refer to community services such as housing support, Centrelink, family relationship centres or local support groups which may then be able to help accessing other services.
Making a referral

If the decision made with the child, young person or family member involves a referral to another service, there are good practice processes you can follow which can help achieve an optimal referral. These are outlined in Box 8.3 and it is acknowledged that many professions and individual organisations already use well-developed processes and protocols which could be adapted.

Box 8.3

OPTIMAL REFERRAL PROCESSES

- **Identify the appropriate service for the referral:** a referral will be most effective if it is directed to a service or agency that is well placed to respond to the specific issues identified — including carrying out a full needs assessment if necessary. This requires current and relevant knowledge about local services, which can be strengthened through local networks and interagency cooperation.

- **Put the child at the centre of the process** — this will often involve striking a balance between assisting the child or family to contact the relevant support services (for example through a warm or friendly referral) and empowering the child or family to take action — for example by encouraging them to make the next steps themselves and subsequently following up with them;

- **Consider making a ‘warm’ or ‘friendly’ referral**: this involves a ‘live’, three-way conversation in the presence of the child/young person/family (whether face-to-face or by telephone) in which you introduce the child/young person/family to the referral source, explain what has already been done to assist them and why they are being referred. Warm or friendly referral is valuable in certain circumstances because it actively engages the family and provides an open and transparent process in which information can be exchanged between you, the child/young person/family in need and the service to which the family is being referred. Issues can be clarified immediately and addressed in front of the child/young person/family. Warm referrals are appropriate where the child/young person/family wish to receive this kind of assistance by the universal service provider.

- **Sharing relevant information:** you should share information that will enable the service receiving the referral to identify what action is needed. When sharing information you must have the informed consent of the child, young person or family member and should follow the principles for optimal information sharing outlined below.

- **Obtaining feedback on the referral:** it is good to obtain feedback on the outcome of a referral to help you understand what has happened and why. This may be particularly relevant if you have an ongoing relationship with the child/young person or family. When you make the referral you should make it clear that you would value feedback on what action is taken and should explain why providing this information to you may be appropriate (i.e. based on the nature of your relationship with the child/young person or family in question). It will be up to each service provider to determine what feedback is appropriate in each case. This may include arranging for general feedback to be provided to your service on the number of referrals that result in additional support as well, or instead of, case-specific feedback.


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6 It is acknowledged that a ‘warm’ or ‘friendly’ referral might not be the preferred referral method for all service providers as it is not always practical and might be time-consuming.

7 For some children/young people/families, warm or friendly referrals may be the appropriate way of making a referral to a support service. In many cases, they ensure that support, treatment and referral are received and that there is follow-up. Participants in the consultations mentioned, for example, that warm referrals might be particularly important in Indigenous communities. However, it is important to note that in some cases, it might be better and more empowering to a child/young person/family if they can take the lead, i.e. if they are given the contact details of a support service or person and then left to decide themselves whether and when to establish contact and seek support. In any case, the decision about a warm/friendly referral needs to be left to the child/young person/family.
Sharing information

Sharing information about the child, young person or family with other service providers is likely to be necessary when making a referral to another support service. You may also need to share information to identify needs and to deliver a coordinated response to a child, young person or family on an ongoing basis. Broad rules to follow for best practice information sharing are outlined in Box 8.4. Again, it is acknowledged that many professions and individual organisations already use well-developed processes and protocols which could be adapted for the Common Approach and which will provide you with more detail on the specific requirements in your jurisdiction.

Box 8.4

GOLDEN RULES FOR INFORMATION SHARING

- **Open and honest communication with children, young people and families.** You should be open and honest with the child, young person or family member from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement. The family then owns the information and knows why it is collected and/or shared.

- **Informed consent from the child, young person or family member to share their personal information.** The Common Approach is voluntary and collaborative and therefore consent to information sharing is essential. Informed consent is a prerequisite for maintaining trust, empowering families and increasing the likelihood of families staying involved in the process. Situations in which the matter of consent is not applicable, for example because the child/young person’s safety is in question, should be dealt with by informing statutory child protection authorities and do not fall under the Common Approach. Mechanisms for obtaining informed consent are detailed further below.

- **Necessary, proportionate, relevant, accurate, timely and secure.** You should ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.

- **Record keeping.** You should keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose. Records can be made either on paper or in electronic format along with other information relating to the child/young person or family. This could involve storing a paper copy of the completed ‘wheel’ in a hard copy file relating to the child/young person or family member, or making notes on the child/young person/family’s electronic file. Information should be stored securely as with other confidential information.

Source: Partly based on UK Government (2009), Information Sharing: Guidance for practitioners and managers.

**Obtaining informed consent**

Before sharing information with another service or professional, you should seek explicit consent from the child, young person or family member to do this. This means explaining clearly and precisely what information you will share and what is likely to happen when the information is passed on. You may find it helpful to explain the benefits of sharing information and also any confidentiality requirements and restrictions that your organisation or profession places on the way information can be shared.
A written record of the consent to share information is preferable to a verbal agreement. Alternatively, the child or family member could take the information with them so that no information is passed on by the professional directly. Key points on obtaining informed consent are outlined in Box 8.5.

Box 8.5

**OBTAINING INFORMED CONSENT: KEY POINTS**

- You should be very clear about the **purpose of the discussion** with a child, young person or parent/carer and potential **implications** of sharing information of a personal nature. Your starting point is one of respect for your clients’ opinions and concerns and acknowledgement of the importance of their own active involvement in discussions and decision-making.
- In general, **information you obtain can only be shared with the informed consent** of the young person and/or parent or carer in question.
- The only exception to this would be cases where the information you are given indicates that **ethical or legal thresholds** may have been reached. In such cases you need to be guided by existing guidelines, ethical codes and legislation relevant to your profession and jurisdiction.
- **For children under 16**, you will generally need the consent of the parent(s) to share information. However it is important to also try to determine the views and wishes of the child or young person and, depending on their age and capacity and the legislation in your jurisdiction, their consent may be sufficient.

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**Whose consent should be sought?**

You should usually seek the consent of the parent or carer to share information both in relation to their own information and information regarding their child, if the child is under 16.

It is also important to try to determine the views and wishes of the child or young person where the information relates to them. Generally children over the age of 12 are considered capable of understanding aspects of their own privacy and information sharing issues and therefore capable of giving (or refusing) consent to share information. In some jurisdictions, the child’s consent may be sufficient for sharing their personal information (for example under the ‘mature minor’ principle) and therefore the parent or carer’s consent may not be needed. This will depend on the legislation in your jurisdiction.

Where parental consent is needed on behalf of a child, the consent of one person will often be sufficient and should usually be sought from the parent with whom the child resides.

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8 The rules around obtaining parental consent for asking a child/young person for information and making referrals are very complex and differ by jurisdiction. In some jurisdictions, children aged 16 and older are seen as able to express their own views, in other jurisdictions the age limit is 14 or younger. There is also the ‘mature minor’ principle (usually applied in the context of medical procedures), which states that even before a child reaches the age at which he or she could consent under the relevant legislation, a child who is considered a ‘mature minor’ may be lawfully competent to give his/her consent. Being a mature minor means that the person has ‘achieved a sufficient understanding and intelligence to enable him or her to understand fully what is proposed’ (see Gillick competence – the ‘Gillick test’ was approved by the High Court of Australia in 1992 in Marion’s case).
Ongoing engagement with the child, young person and/or family

If you have an ongoing relationship with the child/young person or family, you should ensure that they are involved in any subsequent decisions affecting them. This is important for maintaining trust and empowering the child/young person/family. This increases the likelihood that a child/young person or family willingly seeks help, thus increasing the likelihood of an intervention being successful. The processes for involving children/young people/families are as for obtaining consent — the child/young person should be involved as far as possible and in accordance with their capacity and involvement should be sought through discussions with the child, young person or family member (see Practice Principles).
Chapter 9
Practical tips and case studies

How to start a conversation about strengths and needs

When you are convinced that a child or young person has unmet needs (for example, after having used the professional judgement reference point) and you have decided to engage in a conversation with the child/young person/family, at the outset of the conversation it is recommended that you:

• state the purpose of the conversation, for example —
  - “I wanted to spend a bit of time with you today to get to know you/your child a bit better and find out what things are going really well in your life and if there are areas where you/your child might be under some stress and to see if there is anything I can do to help ...”

• explain the process, for example —
  - “I am going to start by asking you a few questions about different aspects of your life to explore your strengths and where things are perhaps not going so smoothly at the moment. After I have asked you some questions we will talk about whether you would like some support to make your life easier/address any concerns or needs you might have and how best to arrange that support...”

• explain the possible ramifications of the conversation, for example —
  - “Some of the things you tell me might suggest that we need to look more closely at what’s happening...” ; and
  - “It is possible that we find out through this conversation that other people/services will be better placed to provide you with the support you may need”; or
  - “Usually I will not tell anyone else what we discuss unless you want me to do so to get you support, but if the issues in your life are very serious I may need to talk to other services to get you/your family more urgent help...”; or
  - “I want you to be aware that through our conversation, we may find that the support you need may go beyond what I can do to help, so we may need to contact other support services.”

You could also state in this context, that all parents are concerned about the wellbeing of their children and that many families have times when things are not that easy, so it is normal to seek and receive help.

As information about the child and family’s situation and issues emerges during the conversation, provide reassurance and emphasise the capabilities you identify. Praise specific strengths and achievements.
How to obtain consent to sharing information and referral

Once you have discussed the child/young person/family’s situation and identified their strengths and needs (for example, by using the prompt questions, the wheel, the self-assessment questionnaire or a combination of the components) and you have a suggestion to make with regards to the next steps, it is recommended that you:

• discuss/recap any issues you have identified with the child/young person/family. You should seek their views on where they consider they might need assistance, for example —
  – “From our conversation, I understand that ... is going really well in your life at the moment but that you are struggling with.../that you would appreciate receiving some support in the area(s) of...”; and
  – “Is my understanding correct?/Would you agree with that?/Is this the way you see things as well?”

• suggest a way forward, for example —
  – “Some of what you told me would suggest that...” or “I believe, from what we have just discussed, that it might be helpful...”

• obtain the child/young person/family’s consent to share this information with the person you think is most suitable to provide the child/young person/family with the support they need, for example —
  – “Are you happy for me to pass on information about the issue you would like help with to...?”

You would then pass the contact details of the relevant person or service to the child/young person/family and if appropriate, suggest a follow-up appointment to hear how it went and provide an opportunity for additional conversation or support. Alternatively, pending your time and capacity, you could offer to make a ‘warm’ or ‘friendly’ referral where this is desired by the child/young person/family.

How to identify strengths and needs by using the wheel

Case study 1: General practitioner, 13-year old child

A GP sees Ben with his mother a few times within three months. Ben is a 13 year old boy who has been telling his mother he feels too unwell to attend school. However, when the GP sees him, Ben can’t describe any physical ailments and he does not appear ill. Ben’s mother mentions to the GP that she is concerned that he is becoming withdrawn and hasn’t been spending much time with his friends after school. Through her core role and professional expertise, the GP identifies that Ben has some depressive feelings and low self-esteem and decides to explore if there are other issues in Ben’s life by having a discussion with Ben and his mother using the wheel.

As the GP is already familiar with the health of Ben and his family, she starts by asking Ben about his relationships:

• Who does he feel close to?
• What’s special about his family?

She establishes that Ben gets on well with his family and is well cared for at home. However, when she speaks to Ben about his friends the answers to these prompts are less positive:

• Who do you spend most of your time with?

• Do you have a best friend?

Ben reveals that he spends a lot of time on his own and doesn’t have a close friend. To explore these issues further, the GP uses the conversation prompts to ask Ben about school and other activities. Initially Ben isn’t comfortable having a conversation about school and becomes quite withdrawn. The GP is concerned about Ben’s general mental health, and believes a follow-up appointment will be necessary. She provides Ben with a copy of the self-assessment questionnaire to fill in at home where he may be more comfortable. The GP makes Ben and his mother a follow-up appointment to discuss his answers to the questionnaire.

At the follow-up appointment, Ben finds it easier to continue the conversation about school. Ben’s answers reveal that he does not enjoy school and no longer enjoys participating in sports and other activities with his school friends. As the GP explores these issues further, Ben reveals that he is being bullied at school. Some of his friends have become friends with the children bullying him and he doesn’t feel that there are other children he can turn to for support.

Using Ben’s questionnaire answers and the conversations they’ve had, the GP circles Ben’s strengths and any identified needs on the wheel as illustrated in Figure 9.1.
Figure 9.1
AREAS OF STRENGTHS AND NEEDS

Note: Strengths are circled in red, needs in blue.
Source: Allen Consulting Group.

The GP then discusses with Ben and his mother how to address his needs in relation to the bullying. As Ben has indicated that a strong point in his life is his relationship with his family, the GP encourages Ben’s mother to arrange a meeting with someone Ben trusts at school, given that the needs relate strongly to the school environment. Reflecting the needs the GP has identified regarding emotional wellbeing and relationships with peers, the GP also explores if there are activities that Ben could participate in that may help him meet some friends outside school and give him a positive focus in his life. As Ben likes sport but doesn’t enjoy playing with the children bullying him at school, the GP searches for sporting clubs in the area to see if there are some that Ben may be interested in. Ben likes the idea of learning a martial art and takes details of a course at a local leisure centre. The GP also arranges to have a follow up discussion to see what progress is made and to consider if any further action needs to be taken. This could include an external referral, for example to psychologist to help Ben address his negative feelings and self-confidence.
Case study 2: School teacher, 8-year old child

A teacher has a concern about one of the students in her class. An 8-year old child’s performance at school has inexplicably declined over the past six months. The teacher has a discussion with the child to identify the strengths in the child’s life and any underlying needs which could be impacting on the child’s school performance. The teacher uses some of the conversation prompts, starting with questions about the child’s learning and development outside school:

- Do you have someone to turn to help you with your schoolwork?
- Do you have a quiet place where you can do your schoolwork?
- What activities do you like doing best?

The child reveals that she enjoys music and sings in the school choir but she does not get much encouragement from her parents in relation to school, or reading. The teacher then decides to explore the relationship domain to understand more about the child’s family. The child reveals that there is not much routine at home and that her mother finds it difficult to stop her brothers arguing and fighting. Exploring these issues further, the teacher identifies that the child’s mother is often unhappy and tired.

The teacher highlights the relevant sectors of the wheel (see Figure 9.2).
The teacher uses the wheel to consider the way forward. As most of the needs lie in the ‘family’ sectors of the wheel and relate to the child’s parent, the teacher is prompted to consider whether and how he might link the child and their family to additional support, initially within the school community. The teacher is also prompted to consider what other services or supports could be needed, perhaps internally through the school counsellor, or through external services such as parenting support. The teacher decides to find an opportunity to speak to the parent to discuss these possibilities further.

**Case study 3: Childcare worker, 4-year old child**

An Early Childhood Education and Care (ECEC) provider has concerns about a 4-year old child attending preschool. At preschool she complains of being hungry and at lunchtime her lunchbox is not sufficiently full for her energy needs. When the weather is cooler she often doesn’t have a jumper and she does not own a raincoat. The child does not participate as actively as her classmates and is not achieving developmental goals at the same rate as her peers.
The ECEC provider refers to the professional judgement reference point and asks herself, ‘Does this child have access to adequate resources?’, and more specifically, ‘does the child have sufficient food and appropriate clothing?’. She then looks over the conversation prompts and considers how to ask the mother if there is enough money to meet the family’s needs, and what she could use to make home a better place to live.

On engaging with the child’s mother in conversation, the ECEC provider finds out that the mother is a single parent of two children, one with physical disability. The mother mentions that things can get difficult at home and that she is often stressed.

The ECEC provider asks if some of the difficulties relate to providing enough food and clothing for the children. The mother mentions that, partly due to the disability of her son and the medical treatments required, the family’s financial situation is strained. In addition, she hardly finds the time to spend with her daughter for simple things like reading to her and asking how her day was, as she feels like her son requires a lot more of her time.

After their conversation, the ECEC provider is able to circle some indicators on the wheel (see blue circles in Figure 9.3):

• enjoyment of school/learning;
• age appropriate development;
• child nutrition;
• reading to children;
• buying food and clothes; and
• health of family members.

The ECEC provider indicates to the mother that she would be happy to have a further conversation to talk about how the family’s situation could be improved. In their conversation the next day, the ECEC provider shows the mother the ‘wheel’ and confirms with her that the circled areas are those where the family might have some need for support.

The ECEC provider then goes on to ask the mother about any kind of support she might currently get or other services that she could easily access but hasn’t done so or any other areas of strengths (e.g. well-functioning relationships) that might help mitigate the current problems.
Figure 9.3
AREAS OF STRENGTHS AND NEEDS

Note: Strengths are circled in red, needs in blue.
Source: Allen Consulting Group.

It turns out that although the mother has some close friends and relatives in the local area who are occasionally able to help out, the family is not currently accessing any community support services for more regular assistance. The ECEC provider consults a local directory of community support services for disabled children and discusses some of the organisations that may be able to offer support.

Together they identify that a local community-based organisation that arranges visits and outings for disabled children could help meet the family’s needs. It would benefit the whole family by offering the mother a regular break from caring for her son and providing time for her to spend exclusively with her daughter. It would also provide an opportunity for her son to meet new people and increase his social interaction. The organisation relies on trained volunteers so there is no direct cost to the family. The ECEC provider makes a phone call to the contact at the organisation and arranges an appointment for the mother to discuss her specific needs and the availability of support services for her son.
The mother also notes that there is a summer reading club in the local library, and that some friends with young children bring the children together to read and play games on some weekends. The mother has a close friend whose children attend the club and thinks that this friend may be able to take her daughter along the next time they go there.

In addition, as it has become clear that some financial assistance, or at least some counselling and help with managing existing resources, would really help the family’s situation the ECEC provider refers the mother to Centrelink, giving her the contact details of the local Centrelink customer service centre.
Appendix A
Self-assessment questionnaire for children and young people
A QUESTIONNAIRE ABOUT YOUR WELLBEING

This questionnaire asks you about various aspects of your life, including your family, your friends and your experience of school or college. It covers issues relating to your health, your feelings and behaviour, education and learning, your family, home and your relationships.

What’s the benefit of completing this questionnaire?
Completing these questions will help you identify those issues in your life that contribute positively to your wellbeing. It will also help you to identify those aspects of your life that are worrying. You will not get a score or an overall ‘result’ from the questionnaire. Instead your answers can help you talk about difficult issues in your life with the people who are in a good position to connect you with some support – like a teacher, your doctor, a youth worker, a counsellor or a community/school nurse.

How to complete the questionnaire
There is a selection of answers for you to choose from for each question. Please select the answer that best reflects how you feel. You do not have to answer particular questions if you do not want to — for example if you do not understand the question; are not sure of the answer; or because you feel that the answer is too private to share at this time.

What happens next?
When you have completed this questionnaire you should discuss your answers with the person who gave it to you to understand what the answers mean for you. If you prefer to leave the actual questionnaire at home, you could just talk about some of your answers in the conversation. If you picked up the questionnaire yourself and would like to discuss your answers, it will be best if you approach an adult that you know and trust that is able to connect you with some support if you need it.

You can also discuss your concerns and get support through Kids Helpline, either over the phone (1800 55 1800) or online at www.kidshelp.com.au.

Where possible your answers will be kept confidential. However, some of your answers may signal that you are potentially in a harmful situation and that other people need to be involved to give you or your family extra support. If this applies to you, the person you talk through your answers with will explain more about how and why other supports need to be involved.
A. PHYSICAL HEALTH

A1. In general, how would you describe your health?
- Poor
- Fair
- Good
- Very good
- Excellent

A2. In an average week, how healthily do you think you eat?
- Excellent
- Very good
- Good
- Fair
- Poor

A3. Have you been to the dentist in the past year?
- No
- Don't know
- Yes

A4. How much of the time do you help care for someone else at home (such as an elderly relative, sibling with a disability or relative with a mental health issue)?
- None of the time
- A little of the time
- Some of the time
- Most of the time
- All of the time

A5. How much of the time can you get the health care you need (such as doctors, nurses and dentists) when you need it?
- Never
- Only occasionally
- Sometimes
- Usually
- Always

A6. How often do you do physical or outdoor activities like swimming, running or team sports?
- Every day
- Most days
- Sometimes
- Only occasionally
- Never

CONSIDERING YOUR ANSWERS TO THE QUESTIONS IN THIS SECTION, HOW HEALTHY ARE YOU OVERALL? (mark an 'x' on the scale to show where you think you are)
Mental Health and Emotional Wellbeing

B1. How much of the time during the past month:

<table>
<thead>
<tr>
<th>Question</th>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you felt satisfied with your life?</td>
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<td></td>
</tr>
<tr>
<td>Have you felt calm and peaceful?</td>
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<tr>
<td>Have you had a lot of energy?</td>
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<td></td>
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<tr>
<td>Have you felt in control of your life?</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you felt upset or stressed?</td>
<td></td>
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<tr>
<td>Have you felt worried about things?</td>
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<tr>
<td>Has your sleep been restless?</td>
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<td></td>
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<tr>
<td>Have you found that your eating is out of control?</td>
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</tbody>
</table>

B2. How much of the time would you say your parent(s) or carer(s) are content?

- None of the time
- A little of the time
- Some of the time
- Most of the time
- All of the time

B3. How many adults are there in your life who you feel you can trust?

- Four or more
- Three
- Two
- One
- None

B4. Has there been a big change in your life that has been stressful?

- No
- Don’t know
- Yes

B5. How often do you feel breathless or like your heart is beating faster than usual?

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

Considering your answers to the questions in this section, how happy would you say you and your family are overall:

(mark an ‘x’ on the scale to show where you think you are)
### SAFETY

**C1.** Many young people experiment with drugs, alcohol or cigarettes. Have you:

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Once or twice</th>
<th>Occasionally</th>
<th>Quite often</th>
<th>Most days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoked cigarettes?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Drunk alcohol?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Taken drugs?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**C2.** Have you ever deliberately hurt yourself?

- ☐ Yes
- ☐ Don't know
- ☐ No, never

**C3.** Have you ever been in trouble with the police?

- ☐ No, never
- ☐ Yes, something minor
- ☐ Yes, something serious

**C4.** Have you been in contact with a social worker, youth worker or Care and Protection person either now or at some time in the past?

- ☐ Yes, a lot
- ☐ Quite a bit
- ☐ On occasion
- ☐ Once
- ☐ No, never

**C5.** Have you ever had an accident or injury at home and had to go to the emergency room of a hospital or medical centre?

- ☐ Yes, more than once
- ☐ Yes, once
- ☐ No
- ☐ Don't know

**C6.** How much of the time do you feel safe at home?

- ☐ None of the time
- ☐ A little of the time
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time

**C7.** How much of the time do you feel afraid at home?

- ☐ None of the time
- ☐ A little of the time
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time

**C8.** How much of the time do people in your family insult or shout at one another?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time
C9. How much of the time in the past year have you been teased in a nasty way at school or at home?

☐ Always  ☐ Usually  ☐ Occasionally  ☐ Once or twice  ☐ Never

C10. Have you been deliberately hit, kicked or threatened by another person recently?

☐ No  ☐ Don’t know  ☐ Yes

C11. How safe do you feel at school?

☐ Very unsafe  ☐ Quite unsafe  ☐ Don’t know  ☐ Quite safe  ☐ Very safe

C12. How safe do you feel in your local neighbourhood?

☐ Very safe  ☐ Quite safe  ☐ Don’t know  ☐ Quite unsafe  ☐ Very unsafe

CONSIDERING YOUR ANSWERS TO THE QUESTIONS IN THIS SECTION, HOW SAFE DO YOU FEEL OVERALL:

(mark an ‘x’ on the scale to show where you think you are)
## MATERIAL WELLBEING

### D1. Do you feel that your family has enough money for basic things like food, clothes and school equipment?
- □ Never
- □ On occasion
- □ Sometimes
- □ Usually
- □ Always

### D2. If things at home are broken, do they get fixed or replaced?
- □ Always
- □ Usually
- □ Don't know
- □ Only sometimes
- □ Never

### D3. Do you have your own bedroom?
- □ No
- □ Sometimes
- □ Yes

### D4. Does your family own a car, van or truck?
- □ Yes
- □ Don't know
- □ No

### D5. Do you have access to the internet at home?
- □ No
- □ Sometimes
- □ Yes

### D6. Do you feel that your house is big enough for your family?
- □ No
- □ Sometimes
- □ Yes

### D7. Do you think your family worries about money or argues about money a lot?
- □ Never
- □ Sometimes
- □ Often
- □ Almost all of the time
- □ Don't know

### D6. Do you think your family worries about the bills a lot?
- □ Almost all of the time
- □ Often
- □ Sometimes
- □ Never
- □ Don't know

---

Considering your answers to the questions in this section, how well off do you think your family is? (Mark an 'x' on the scale to show where you think you are)
E1. Do you like school?

- [ ] Never
- [ ] Sometimes
- [ ] Most of the time
- [ ] Always
- [ ] Don’t know

E2. Do you miss many classes at school or college?

- [ ] Almost all of the time
- [ ] Usually
- [ ] Sometimes
- [ ] Very rarely
- [ ] Never

E3. How well do you think you are doing at school or college?

- [ ] Bottom of the year
- [ ] Below the middle
- [ ] In the middle of the year
- [ ] Above the middle
- [ ] Top of the year

E4. How often do you need extra help with learning to make sure you do your best?

- [ ] Most of the time
- [ ] Quite often
- [ ] Sometimes
- [ ] Only occasionally
- [ ] Never

E5. Do you have someone to turn to outside school for help with your schoolwork?

- [ ] Never
- [ ] Only sometimes
- [ ] Sometimes
- [ ] Quite often
- [ ] Most of the time

E6. Do you have a quiet place where you can do your schoolwork?

- [ ] Most of the time
- [ ] Quite often
- [ ] Sometimes
- [ ] Only occasionally
- [ ] Never

E7. Do you participate in any groups or clubs outside school?

- [ ] Never
- [ ] Only sometimes
- [ ] Sometimes
- [ ] Quite often
- [ ] Most of the time

E7. How many schools have you attended?

- [ ] One
- [ ] Two
- [ ] Three
- [ ] Four
- [ ] More than four

CONSIDERING YOUR ANSWERS TO THE QUESTIONS IN THIS SECTION, HOW SATISFIED ARE YOU WITH YOUR LEARNING AND DEVELOPMENT?  
(mark an ‘x’ on the scale to show where you think you are)
## RELATIONSHIPS

### F1. Do you usually feel like you belong when you’re at school?

<table>
<thead>
<tr>
<th>Never</th>
<th>Not usually</th>
<th>Sometimes</th>
<th>Quite often</th>
<th>Very often</th>
</tr>
</thead>
</table>

### F2. How often do you spend time with friends outside school or college?

<table>
<thead>
<tr>
<th>Never</th>
<th>Only occasionally</th>
<th>Sometimes</th>
<th>Quite often</th>
<th>Very often</th>
</tr>
</thead>
</table>

### F3. How often did you feel good about yourself last week?

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
</table>

### F4. How often do your parent(s) or carer(s) spend time just talking with you?

<table>
<thead>
<tr>
<th>Not often at all</th>
<th>Only occasionally</th>
<th>Sometimes</th>
<th>Most days</th>
<th>Every day</th>
</tr>
</thead>
</table>

### F6. How many times a week do you eat meals with your parents or carers?

<table>
<thead>
<tr>
<th>At least one meal every day</th>
<th>Most days</th>
<th>Some days</th>
<th>Twice a week</th>
<th>Once a week or less</th>
</tr>
</thead>
</table>

### F7. How often do you use local facilities such as sport centres, swimming pools, parks or libraries?

<table>
<thead>
<tr>
<th>Never</th>
<th>Not very much</th>
<th>Sometimes</th>
<th>Quite a bit</th>
<th>Very often</th>
</tr>
</thead>
</table>

### F8. Do you and your family go on outings together, e.g. films, day trips, local activities or events?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Sometimes</th>
<th>Quite often</th>
<th>Very often</th>
</tr>
</thead>
</table>

### F9. Are there people in your neighbourhood or community that your parents or carers can turn to for help when they need to?

<table>
<thead>
<tr>
<th>Yes</th>
<th>Sometimes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
</table>

### F10. How many times have you moved house in the past year?

<table>
<thead>
<tr>
<th>More than twice</th>
<th>Twice</th>
<th>Once</th>
<th>Not at all</th>
<th>Don’t know</th>
</tr>
</thead>
</table>

### F11. Do you sleep away from home often?

<table>
<thead>
<tr>
<th>No, not often</th>
<th>At times</th>
<th>Yes, often</th>
</tr>
</thead>
</table>

### F11. Has anyone in your family been involved with the police?

<table>
<thead>
<tr>
<th>Yes, something serious</th>
<th>Yes, something minor</th>
<th>No, never</th>
</tr>
</thead>
</table>
CONSIDERING YOUR ANSWERS TO THE QUESTIONS IN THIS SECTION, HOW WELL DO YOU THINK YOU RELATE TO YOUR FAMILY AND FRIENDS? 

(mark an ‘x’ on the scale to show where you think you are)

NOT WELL

__________________________

V E R Y  W E L L

ADDITIONAL COMMENTS

Are there any other comments that you would like to make in regard to the above questions?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

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