



every child every chance

a good childhood is in everyone's best interests

Children and their families

Best interests case practice model

Specialist practice resource

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2012

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About specialist practice resources

The *Best interests case practice model* provides you with a foundation for working with children and their families. *Specialist practice resources* are designed to provide additional guidance on information gathering, analysis and planning, action and reviewing outcomes in cases where specific problems exist or with particular developmental stages. This resource is informed by current evidence related to the engagement of and professional practice with children.

This resource is in two parts. Part One focuses on children, their development, and how past trauma and other events affect development. Part Two looks at ways of working with children and their families. The resource will provide you with information, strategies and tips to engage children and understand and respond to specific issues that are common for children and their families who use our services. You will be able to use these skills to gather information and make assessments about abuse and neglect allegations, behaviours, placement decisions and other issues when working with children.

For child protection practitioners, the *Child Protection Practice Manual* contains information about procedural requirements, practice standards and advice. The *Children and their Families specialist practice resource* does not replace the *Child Protection Practice Manual*, but complements it and helps you to be an effective practitioner as you fulfil your statutory requirements.

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Overview

What is childhood?

The Children, Youth and Families Act (2005) defines a child as a person who is under the age of 17 years. This resource focuses on children aged 3-10 years, although some of the information may be relevant for infants and adolescents.

For information and resources for working with infants and their families, see the [Infants and their families specialist practice resource](#). For information and resources for working with adolescents and their families, see the [Adolescents and their families specialist practice resource](#).

The focus of any assessment and intervention is to answer the questions “Is the child safe?” and “How is the child developing?”

Child development

Good practice in working with children requires an understanding of child development, in order to generate some hypotheses about whether deviations in what is considered ‘normal’ development for a particular age are a result of neglect and/or abuse, or naturally occurring variations. There exists a large number of medical conditions that cause, and are associated with, developmental delay. These conditions include genetic, neurological and metabolic illnesses, syndromes and chronic medical conditions. This section outlines the developmental trajectory of a healthy child aged 3 to 10. It is important to note that children will develop in different ways and at different times. The points below are generalisations relating to healthy development and need to be understood in the context of the child’s culture.

For more specific information on developmental trends for children at different ages, and possible indicators of trauma, refer to the [Child development and trauma specialist practice resource](#).

Assessment processes, actions, decisions and planning involving children and young people should take account of their developmental level across a spectrum of ‘life worlds’, including health, education, identity, family and social relationships, social presentation, emotional and behavioural development and self care (Winkworth and McArthur 2006, p. 20).

The preschool years (3–5 years)

As development is sequential, what happens developmentally in the preschool years depends on what happens in the earlier years. Children in the preschool years are becoming increasingly independent and engaging with others, although they will continue to seek comfort and reassurance from parents and caregivers. Preschool-aged children are starting to make friendships but may need adult help to negotiate conflict and manage emotions. Coordination is improving, and running, climbing, throwing and catching a large ball are activities the preschooler can increasingly engage in. Preschool children learn through play, and safe nurturing relationships are crucial for every aspect of their development.

From a cognitive perspective, preschoolers are very much self-centred in their thinking and may not yet comprehend that other people think differently, although more recent research suggests that social context is important and there is some capacity for empathy by this age. Language use is increasing, with communication occurring in simple sentences and 1000 to 3000 words are understood.

The early school years (5–10 years)

Children in their early school years are increasingly confident, independent, and able to manage their own emotions, however family relationships remain central to their healthy development. Friendships become very important, although they may change regularly in the early years. By the age of 7 to 9, peers become increasingly important and begin to exert influence on a child's self-esteem. Older children begin to contribute to long-term plans and engage in more detailed and complex conversation.

Formal education, usually through kindergarten and schools, develops literacy and numeracy skills. School attendance has a significant impact on the development of social skills and self-confidence, although in the early years the most valuable learning still occurs through play. School bullying, however, can have negative consequences for children, including psychological and physical harm and social isolation. Longitudinal studies confirm school bullying as having a significant causal negative effect on health and wellbeing (Lodge 2008). Conversely, a strong connection to school and at least one key teacher, may provide an important protective factor for young people living in families with multiple problems (Dawe, Harnett and Frye 2008).

From the age of about 7, children become less egocentric, are actively engaged in figuring out how things work and using logic to solve problems. 'Magical thinking' at this age, however, may still lead children to believe that something in the external world is occurring because of them. For example, 'Mummy and Daddy don't live together any more because I was naughty'. These distorted beliefs can remain powerful into adult life, particularly in self-blame, for example, 'The abuse was my fault'.

Health and wellbeing

The *State of Victoria's Children Report (2010)* continues to report on health and wellbeing trends and issues facing this age group of Victorian children, including:

- A significant proportion of children are overweight or obese (based on physical measurements: 12.4 per cent of 2 year olds, 15.4 per cent of 3-4 year olds and 25.3 per cent of children aged 5 to 17). The *State of Victoria's Children Report (2006)* indicated that changes in children's dietary intake to energy-dense foods and drinks was up by 13 per cent.
- Of the 35,720 reported family violence incidents in 2009-10, a total of 14,870 children and young people aged 16 or less experienced these incidents. The number of children identified as 'aggrieved family members' (victims) in finalised family violence intervention order applications in Victoria has increased dramatically, from 5310 in 2003-04 to 15,399 in 2007-08, due largely to legislative and practice changes.
- In 2010, almost half (49.2 per cent) of Victorian young people aged 12 to 14 report having experienced bullying. In the *State of Victoria's Children Report (2006)*, one-fifth of parents of children aged 4 to 12 reported their child was involved in being bullied or bullying.

- Almost 4 in 10 Victorian children have been exposed to a significant stressful event by the time they start school (for example, the death of a family member, parental divorce, or an illness of their parents or siblings), with Aboriginal children and those from one-parent families more likely to have been exposed to multiple stressors. **Victorian Aboriginal families have almost double the rate of experiencing major life stresses than non-Aboriginal Victorian families (DEECD, 2010 b)**
- About 5 per cent of Victorian children aged 5 to 6 experience emotional or behavioural difficulties and are considered to be at high risk of significant clinical problems. About 7 per cent of children are also considered to be at a high risk of hyperactivity or conduct problems at school entry.
- Children are less likely to do the recommended level of physical activity (at least one hour a day) as they get older, and are more likely to spend two hours or more each day using electronic media. Sixty per cent of Victorian children aged 5 to 12 are physically active for / at least one hour per day, compared with just 12 per cent of young people aged 12 to 17.
- Almost one in five children aged 5 to 12 spend two hours or more each day using electronic media (18.8 per cent), compared with almost three in five young people aged 12 to 17 (58.7 per cent).
- 26.6 per cent of 5 year olds have never visited a dentist.

Across almost all issues detailed in the *State of Victoria's Children Report*, children, young people and families from disadvantaged backgrounds fare less well on many measures including:

- less likely to be a healthy weight and meet fruit and vegetable intake guidelines
- more likely to have poorer oral health, as indicated by more reported fillings and extractions and lower use of dental services
- more likely to have emotional and behavioural problems that are of concern
- more likely to be developmentally vulnerable at school entry
- more likely to experience bullying, to have skipped school or to have been suspended
- more likely to have been involved in antisocial or criminal behaviour
- more likely to be exposed to tobacco in the home. (Department of Education and Early Childhood Development [DEECD] 2010).

Children's health needs change over time. It is important to talk with health professionals, for example, the GP or paediatrician who has seen the child within recent months to clarify current health needs. Use this opportunity to ask questions so that you fully understand the child's condition and what this means for the child and for his carers. For children with chronic illness or disability, consider requesting a case conference with the child's treating medical and allied health team to assist you to understand and assess the implications of health needs for the child.

Non-accidental injury

Practitioners need to focus on the child and their needs and to be forensically astute, so careful attention must be paid to physical injuries. If practitioners SUSPECT that non-accidental injury may have occurred, the child needs to be evaluated by a medical professional with the knowledge and skills to differentiate non-accidental injury from accidental injury and/or medical conditions that might be confused with abuse. It is important for practitioners to document and consider the significance of bruising and injury patterns that may indicate non-accidental injuries upon children and also injuries suffered as a result of neglect.

Child protection practitioners must consult with the Victorian Forensic Paediatric Medical Service and seek an urgent forensic medical examination if you suspect that a child has been injured as a result of abuse or neglect. We must be alert to the possibility of non-accidental injury when we observe injuries on a child, or hear a story that suggests that a child might have been injured. More information on identifying non-accidental injury and working with children and families can be found in the Information Gathering section on p.42

The importance of family

The importance of family and family relationships has become increasingly recognised in outcomes for children, including a greater understanding of which family characteristics have the most significant impact. Research findings include:

- The quality of parenting is the most highly significant influence on positive child development (Masten & Shaffer 2006, Zubrick et al 2008).
- Parenting styles measuring high in hostility and low in warmth and consistency, even where subtle, and within the 'normal' range of parenting behaviours, will negatively impact on child outcomes (Zubrick et al 2008).
- Child outcomes are shaped by the degree to which parents define limits, enforce rules and monitor behaviour, balanced with support for age-appropriate autonomy (Luthar 2006).
- Family processes (parenting style high or low in warmth, level of conflict between parents) have more influence on a child's current and future wellbeing than family structure (number, gender or sexuality of parents) (Amato & Fowler 2002, Burke, McIntosh & Gridley 2007).
- Children from separated families are at significantly greater risk of poor outcomes, with risks persisting into adulthood. However, poor outcomes often exist before separation, indicating that other indicators of long-term disadvantage are already in place for these children (Pryor & Rodgers 2001).
- Fathers' involvement in child development and growth is important, both directly and through supporting the mother (Berlyn, Wise & Soriano 2008, Fletcher 2008).

For best outcomes, children need parenting that shows warmth and affection and is consistent in setting appropriate boundaries.

Working with a child's temperament

The 'fit' between the parents' capacity and parenting style and child personality is important (Masten & Shaffer 2006). Smart (2007) talks about the importance of working 'with' rather than 'against' the child's temperament, and that parents can help understand their child's temperament by engaging in observations of their child's style over time, or completing temperament-focused questions. They can then be encouraged to focus on their parenting techniques and how a good 'fit' can be achieved between child and parent. Environment and context also play a role in how temperament is exhibited – for example, an active child may be better suited to a daily routine where parents or carers are pro-active about increased, regular outdoor activities.

Attachment and maltreatment

Positive attachment relationships between parents/caregivers and children are considered crucial to development. Sensitive and responsive caregiving from the primary attachment figure (usually the mother) builds a secure child-caregiver relationship and promotes optimal physical, behavioural, social and emotional development. This includes a greater capacity for emotional regulation, positive social interactions and better coping skills. Attachment to caregivers is fundamental, through influencing learning, reactions to threat, exploration and as a regulatory mechanism, for example, comforting a scared child (Masten & Shaffer 2006). For more information on attachment theory, see the *Infants and their families specialist practice resource*.

Although the importance of attachment relationships is often associated with the infant and early childhood years, such relationships continue to influence development well into adolescence and beyond. There is evidence that the quality of primary attachment relationships in infancy and early childhood can influence later relationships with peers and partners in adolescence and early adulthood (Daniel, Wassell & Gilligan 1999), although the continuity and influence of these relationships is complex.

Disruptions to attachment relationships can occur due to problems with the infant, the caregiver, the environment, or the 'fit' between temperaments and capabilities of the caregiver and child.

Maltreatment by an attachment figure can be more damaging to a child than maltreatment by a stranger (Masten & Shaffer 2006). Even when primary caregivers are abusive, the child is likely to continue to be attached to them. The child will often want the abuser's love and affection even though they simultaneously want the abuse to stop. Abuse may not be consistently present; the abuser may be affectionate and abusive in turn.

This type of relationship may be amenable to become more protective and affectionate (Doyle 2006). However, this needs careful assessment because the harm to the child may be so serious that they need protection from the abusive or neglectful parent. Key considerations are the parents' willingness to change and demonstrated capacity and commitment to prioritising the child's needs.

Siblings

Sibling relationships are often our longest-lasting relationships, however it is interesting to note that research has focused largely on differences between families rather than within families. Sibling rivalry is often the only aspect of sibling relationships that receives attention in research and practice (Young 2007). Yet the quality and impact of sibling relationships can be a significant factor in child outcomes. The warmth and care shown by siblings can be significant protective factors for vulnerable children.

The Children, Youth and Families Act (2005) provides for consideration to be given to access arrangements between children and their siblings, and the desirability of siblings being placed together in out-of-home care, when determining decisions in the best interests of the child (s. 10 (k) and (q)).

Research on siblings shows that:

- Siblings can be protective and supportive allies, or they can be competitive rivals, or both at different times (Sanders 2004).
- Siblings may be significantly impacted upon where parental support and attention is focused on a child with special needs (AIHW 2004).
- Older siblings often hold more power, whereas younger siblings are working hard to preserve the relationship (Noller & Blakely-Smith 2007).
- There is little agreement across parents as to the appropriate age for a child to supervise younger siblings, yet there is a greater risk of injury to a child who is being supervised by an older sibling (Morrongiello, Maclsaac & Klemencic 2007).
- The most likely reason for sibling supervision is a lack of human resources, such as access to informal carers before or after school (de Vaus & Millward 1998; Morrongiello, Maclsaac & Klemencic 2007).

It is important to note that sibling supervision at young ages is an accepted norm in many cultures, including Aboriginal and Torres Strait Islander cultures. Consideration needs to be given to the danger and risks involved in the particular circumstances and safety is always the main consideration. The maturity and specific needs of the siblings involved, along with family dynamics, need to be considered. Seek further advice from cultural consultants and supervisors.

Sibling abuse

Another important issue is abuse perpetrated by siblings. One Australian study (Hatch 2005) showed that access to children was the prevailing factor in who was chosen as a victim of sexually abusive behaviours, with siblings most likely to be the victim of adolescent perpetrators. Sibling victims of abusive adolescents were more likely to be female, aged ten or younger, and the abuse was more likely to involve penetration and more likely to have continued for more than a year (Hatch 2002).

Sibling abuse fails to draw the same attention as adult abuse of a child due to the perception that it is part of 'normal' sibling rivalry or sibling relationships. For example, sexual behaviour of siblings can be seen as normal sex play or exploration rather than sexual abuse, even though there is growing evidence of its significant consequences (Rowntree 2007). Sexual behaviour may begin as mutually agreed behaviour, but at a time when one sibling wishes to stop, the other sibling may pressure them to continue. Power differentials, duration, differences in physical size, the presence of threats and coercive behaviours all characterise the difference between exploratory and abusive behaviours (Carlson, Maciol & Schneider 2006; Rowntree 2007). Where there are indicators of abuse, any siblings, particularly younger siblings or siblings with a developmental delay or intellectual disability, should be assessed for risk of sibling sexual abuse because of their heightened vulnerability.

Refer to the [Children with problem sexual behaviours specialist practice resource](#) and the [Adolescents with sexually abusive behaviours and their families specialist practice resource](#) for further guidance on how to assess and work with children exhibiting problem sexual behaviours.

Disability, global developmental delay and developmental delay

Developmental delay

Child abuse and neglect can be a major factor influencing all aspects of development and so it is important to understand terms relating to developmental delay and disability. Neglect in particular can indicate that the child has not had his/her developmental needs met and this may lead to developmental gaps. In addition to assessment of development, planned strategies and support are needed to assist the child.

It is important for practitioners to understand precisely what is meant when children are referred to as having developmental delay or global developmental delay. Parents are often confused by these terms and practitioners can play a vital role in supporting parents emotionally and in clarifying, in plain language, what these terms mean for their children in consultation with appropriate specialists.

Developmental delay is defined in the *Disability Act 2006* (section 3) as a delay in the development of a child under the age of 6 that:

- (a) is attributable to a mental or physical impairment or a combination of mental and physical impairments; and
- (b) is manifest before the child attains the age of 6; and
- (c) results in substantial functional limitations in one or more of the following areas of major life activity –
 - self-care
 - receptive and expressive language
 - cognitive development
 - motor development; and
- (d) reflects the child’s need for a combination and sequence of special interdisciplinary, or generic care, treatment or other services that are of extended duration and individually planned and coordinated.

Developmental delay is an umbrella term used to describe a delay in a young child’s development compared to other children of the same age. Developmental delay may manifest itself in gross or fine motor skills, or speech and language abilities.

Global developmental delay

There is no consensus about the definition of *global developmental delay* (Petersen, Kube & Palmer 1998). The term refers to a disturbance in an individual child aged 0-5 years only, with no diagnosis (AIHW 2003), across two or more developmental domains. These delays in achieving milestones in domains are directly observable and measurable in the context of the natural progression of children. These domains include gross/fine motor, speech/language, cognition, social/personal and activities of daily living (Shevell 2008). These delays are defined when performance in at least two domains is at least two standard deviations below the mean on age appropriate, standardised norm reference tests (Williams 2010).

A diagnosis of global developmental delay in a child aged over 5 (6th birthday or older) is not appropriate. Section 3 of the *Disability Act 2006* specifies developmental delay as a condition in a child aged under 6 while section 6(3) of the Act outlines how a determination is made if a person over 5 has an intellectual disability.

The use of the term ‘delay’ within global developmental delay suggests the possibility of maturational catch-up, however research suggests otherwise. Most children with late acquisition of several milestones will experience intellectual disability (Williams 2010). This does not mean growth and developmental gains are impossible, but that if chronic and extensive gaps exist, it will take persistent and targeted intervention and the level of growth may not be the same (Perry 2001& 2002).

Children with autism are not classified as having global developmental delay. The diagnosis of autism takes hierarchical dominance over global developmental delay (Williams 2010). Assessments of global developmental delay should be informed by:

- family history, prenatal, perinatal and postnatal history, the child's medical history and developmental history
- direct physical evaluation of the child
- laboratory investigations if indicated
- opinions from other parties such as therapists and teachers
- input from an interdisciplinary team and
- the use of standardised tests of development and intelligence (see McDonald et al. 2006; Williams 2010).

Disability

Disability is defined in the Disability Act (section 3) as:

- (a) a sensory, physical or neurological impairment or acquired brain injury or any combination thereof, that:
 - (i) is, or is likely to be, permanent; and
 - (ii) causes a substantially reduced capacity in at least one of self-care, self-management, mobility or communication; and
 - (iii) requires significant ongoing or long-term episodic support; and
 - (iv) is not related to ageing; or
- (b) an intellectual disability; or
- (c) a developmental delay.

Disability is not uncommon in Australia, with an estimated 8 per cent of children having a disability (Australian Bureau of Statistics 2004). The prevalence of disability is increasing, from 5.3 per cent in 1981 to 8.3 per cent in 2003, with intellectual/learning and physical/diverse disabilities most common among children (AIHW 2009). The extent of a disability can impact on a child's participation in schooling and other activities and can restrict the child's involvement in society. Childhood disability can also have a significant impact on the family, with caring responsibilities often placing strain on family relationships and impacting on employment and finances.

Research has found that children with a disability are more likely to be victims of abuse and neglect, with one US study finding that children with disabilities were 3.4 times more likely to be neglected, and physically, emotionally, or sexually abused compared with non-disabled children (Sullivan & Knutson 2000). Australian research on the topic is limited but one Australian study has shown that neglected children were four times more likely to have some form of physical or intellectual disability (Barber & Delfabbro 2009).

The impact of disability on a child's functioning, and the effect this has on families and the way they cope, is an important consideration for practitioners. It is critical that appropriate consultation occurs with colleagues in the disability field and that children have timely access to financial resources, early intervention services and specific educational assistance. These need to be put in place to support the family.

The child's health professional should be asked to produce a care plan with Medicare funding. Regular monitoring and reappraisal of interventions, tailored to meet the child's needs, must be put in place that are mindful of the support required by the family to provide what the child needs. Exploring grief and loss issues with parents about the child they hoped to have, may help parents accept and readjust their expectations of their child who has a disability.

The difference between global developmental delay, developmental delay and disability

Global developmental delay is not specified in the *Disability Act*. The difference in the definitions between developmental delay and global developmental delay is that developmental delay describes limitations in one developmental domain and global developmental delay refers to substantial delays in development in two or more domains.

There may be indicators of intellectual disability during infancy or early childhood but it is best diagnosed during the school years (Battaglia & Carey 2003). This supports the need for review of children assessed as having developmental delay or global developmental delay when they are older than 6 years, in order to more accurately diagnose the condition and describe their support needs.

Examples of specialists who can provide assessment and recommendations include Maternal and Child Health Nurses, general practitioners, paediatricians, psychologists, speech therapists, physiotherapists occupational therapists, neuropsychologists, and teachers.

The developmental stages of children we are working with need to be carefully assessed, with the assistance of appropriate specialists when required. If developmental gaps are identified, intensive, creative work with children will be needed to support them in these areas. The effectiveness of these interventions needs to be regularly assessed.

The prevalence of loss and grief

Children involved in the child protection system are more likely to have experienced multiple losses and suffer grief that can be easily overlooked by professionals and masked as difficult, defiant, or withdrawn behaviour. This can be compounded by their experiences such as removal from family, severing of significant relationships and the potential for multiple placements and changes in carers and practitioners. The loss of pets and changes in houses, neighbourhoods and schools can have a deep and cumulative impact on children.

Take Two is a Statewide developmental therapeutic program for children and young people in the Child Protection system run by Berry Street's Take Two program in partnership with LaTrobe University, Mindful Centre for Training and Research in Developmental Health and the Victorian Aboriginal Child Care Agency. The organization works intensively with the distressed child or young person, and their carers, families and teachers, to help them understand their pain and learn to trust again. Take Two also provides training, research and consultancy and is funded by the Department of Human Services.

Their research shows that for children entering the child protection system, loss and grief was found to be a profound and consistent theme since the first Take Two evaluation report (Frederico, Jackson, Black 2005). A survey completed by Take Two in 2010 explored children's experiences of loss and whether parents experienced additional adverse experiences. Of the 527 children whose response was known, 18 per cent had at least one deceased parent (Frederico, Jackson & Black 2010).

Having a parent or both parents in prison was also identified as a source of loss and grief for children. Of the 229 children where a response was known in the clinician's survey, 30 per cent (n=69) had one or more parents who had been in prison during Take Two's involvement. Twelve children (5 per cent) had two or more parent figures in prison. This finding highlights a range of issues for children including their additional experiences of loss, uncertainty, grief and fear for their parents' safety. The experience of visiting parents in prison can be confusing, distressing and even shaming for children. It is an overt sign of the parent's level of criminal activity that can have other consequences for children such as affecting their moral development (sense of right and wrong), lack of access to pro-social models of behaviour, sense of exclusion from society and potential exposure to, and inclusion in, criminal culture (Frederico, Jackson & Black 2010).

Children and trauma

Small 'doses' of stress in childhood and appropriate, healthy responses initiated within a normal parent-child interaction are an important aspect of development that help a child to develop coping skills. Overwhelming stress, on the other hand, can interfere with normal development (Szalavitz & Perry 2010). Trauma occurs when people are exposed to frightening and overwhelming circumstances from which they cannot escape or to which they cannot give meaning, and children are particularly vulnerable given their developmental capacities. A freeze/flight/fight response is activated, the body is flooded with a biochemical response (including adrenalin and cortisol) (Bloom 1999) and if stuck in this condition, the consequent dysregulated and hypervigilant state impacts on brain development and behaviour (Miller 2009).

Children who are exposed to repeated, traumatic experiences are unable to experience the safety and protection that is needed for brain development to occur normally, and as a result may be chronically irritable, angry and unable to manage emotions (Bloom 1999).

Van der Kolk (2005) suggests that many perceived behavioural problems exhibited by traumatised children are efforts to minimise threats and regulate distress arising from the trauma, but are more likely to be labelled as ‘oppositional’, ‘rebellious’ or ‘antisocial’. Perry (2001(b)) has further suggested that diagnoses of disorders such as attention deficit hyperactivity disorder and conduct disorder are less likely to occur when there is a greater understanding of the impact of trauma on child behaviour.

Children and young people who are consistently in an ‘alarmed’ state as a result of trauma are less efficiently absorbing cognitive content, but more efficiently absorbing relational content. As such, they are more likely to be seen as impulsive or disengaged in classrooms and other settings, leading to negative reactions from authority figures. School is often the first place where signs of trauma are noticed, so a greater understanding of managing child behaviour from a trauma perspective is needed. Encopresis (involuntary defecation) and enuresis (involuntary urination) as a result of trauma can also cause problems and stigmatise the child at school.

One response to trauma is a mental ‘escape’ (dissociation), a mechanism by which a person withdraws attention from the outside world and focuses within (Hellett & Simmonds 2003; Perry 1994). This may involve a detached feeling, a sense of observing the event, or withdrawal into a fantasy world. The intensity of dissociation varies with the intensity of the event, and it may become a primary adaptive response to coping with repeated traumatic experiences (such as abuse, neglect or family violence).

Certain factors influence the level of trauma associated with a particular event, including:

- age, gender and developmental stage of a child
- the relationship they have to the perpetrator (the closer the relationship, the greater the impact on the child)
- inability of a caregiver to protect a child against a perpetrator
- the gender of the perpetrator and victim
- the severity, frequency and duration of traumatic events.

The work of Bruce Perry¹ and Sandra Bloom² provide examples of recent models of trauma response and treatment. Patterns of intergenerational trauma should be included in assessments, because many children will have parents and other family members with their own trauma history. This family history is vital information in analysing and planning how we can help the child.

Refer to the Child Development and Trauma specialist practice resource for further guidance on the impact of trauma on child development.

1. See: <http://www.childtrauma.org/>

2. See: <http://www.sanctuaryweb.com/>

Complex trauma and cumulative harm

Where trauma is repeated and prolonged (characterised by multiple and repeated abuse and neglect or exposure to family violence), it is referred to as 'complex trauma' (van der Kolk 2005). The experience of complex trauma has been compared to being held in captivity, and subjected to continued and prolonged terror, subjugation, isolation and enforced dependency (Herman 1997). This may also be coupled with small rewards or concessions which, over time, destroy the victim's sense of self and autonomy.

Harm caused by multiple adverse circumstances and events accumulates and can damage the developing brain (Bromfield, Gillingham & Higgins 2007; Van der Kolk 2005). Chronically traumatised children can have distinct changes in their levels of consciousness, and can be completely out of touch with feelings or internal states. Familiar things, even if they are predictable sources of terror, are experienced as safer.

The *Children, Youth and Families Act (2005)* (s. 10 (3)(e)) requires practitioners to consider the effects of cumulative patterns of harm on a child's health, safety and development. For guidance on recognising, assessing and responding to cumulative harm, refer to the Cumulative Harm specialist practice resource.

Identity, resilience and strengths

When analysing and planning how to respond to a child's situation, it is important to not get locked into a 'problem' mindset. Longitudinal research indicates that an 'absence of maltreatment' does not equate with 'doing well'. The importance of high-quality parenting, an active investment of love, encouragement and affection from a parent or caregiver is seen as influential on 'doing well' in adulthood, rather than just an absence of adverse experiences. This indicates the need for the child and family welfare sector to focus on strengthening protective factors (for example, positive relationships with caregivers) rather than just minimising risk factors (such as child maltreatment) (Price-Robertson, Smart & Bromfield 2010). Rutter (2006) similarly describes the need to target prevention to reduce risk and enhance health promotion, and target the processes that lead to positive functioning despite the experience of serious adversity – the phenomenon of resilience.

Children who experience adversity can bring a range of personal strengths, coping strategies, and ways of eliciting support to the situation. Intervention and prevention should help increase children's self-talk about their strengths and abilities, holding hope and succeeding, and reframing the difficulties that they face.

Aboriginal and Torres Strait Islander children

Aboriginal and Torres Strait Islander children are over-represented in child protection and out-of-home-care services compared with other children, a situation that has not changed since the first collation of data in 1990. While Aboriginal and Torres Strait Islander children comprised 4.6 per cent of Australian children in 2008–09, they constituted 25 per cent of all confirmed reports of abuse or neglect, and are 9.2 times more likely to be placed in care

(Australian Institute of Health and Welfare [AIHW] 2010). Aboriginal children in Victoria are considerably more likely to be the subject of a substantiation compared with non-Aboriginal children (48.3 Aboriginal children compared with 2.8 non-Aboriginal children per 1000), and 11 times more likely to be the subject of a protection order (Department of Education and Early Childhood Development [DEECD] 2010).

The most frequently experienced form of maltreatment experienced by Aboriginal and Torres Strait Islander children in 2008–09 was child neglect (AIHW 2010). This is consistent with disadvantaged socio-economic conditions such as overcrowding and unemployment, evident in many Indigenous communities (Calma 2008). Sexual abuse was the least frequently substantiated maltreatment type for Aboriginal and Torres Strait Islander children, but this is likely to be an underestimation because sexual abuse is considered to be grossly under-reported (Berlyn & Bromfield 2010). It should be noted that sexual abuse is the least frequently substantiated abuse type also for non-Indigenous children. Health issues such as hearing and dental problems are also over-represented in Aboriginal children, as are the number of children with a disability requiring assistance with core activities (DEECD 2010).

Importance of culture and community

Traditional Aboriginal culture sees the individual as living and being in relationship with family, community, tribe, land and spiritual beings of the law and dreaming. Culture and the maintenance of culture are seen as central to looking after children and healthy Aboriginal child development (Larkins 2010). Bamblett & Lewis (2007) suggest that much of child protection practice has, in contrast, traditionally focused on individualistic notions of the child, which is at odds with these broader relationships and how they inform a sense of identity. Denying cultural identity is seen as detrimental to attachment, emotional development, education and health. As such, the Aboriginal Cultural Competence Framework suggests that family should be involved in defining who should be included in assessments, planning and interventions (Department of Human Services 2008).

Culturally competent practice is essential in the statutory system, due to a history of policies that have inflicted so much pain and trauma (Bamblett & Lewis 2007; Miller 2009). The legacy of dislocation from kin, culture and country as a result of the 'Stolen Generations' policies and related practices, as well as the institutionalised abuse and neglect suffered by many removed children, continues to impact on Aboriginal and Torres Strait Islander families (Human Rights and Equal Opportunity Commission 1997; Zubrick et al 2005). One outcome that child protection practitioners should be aware of is the highly significant consequence this has had on the parenting capacity of adults who were removed from their families as children (Zubrick et al 2005).

It is important to recognise the strength and resilience of Aboriginal and Torres Strait Islander people and culture in the face of this adversity. Kinship systems and connection to spiritual traditions, ancestry and country are important strengths to draw upon in Indigenous communities. The role of family is also critically important, with Aboriginal and Torres Strait Islander children more likely than non-Aboriginal children to be supported by an extended and often very close family (Victorian Aboriginal Child Care Agency [VACCA] 2006).

Being culturally sensitive does not mean accepting a lower standard of safety for children. As a summary, VACCA (2006) describes that best practice by child protection staff is demonstrated through:

- understanding the impact of past policies and practices
- understanding the role of the whole family and the entire community
- understanding the role of culture and identity
- being strengths-based and holistic
- acknowledging the diversity of indigenous culture and lifestyle.

Practitioners can find many good resources that will help them understand the impact of colonisation and the Stolen Generations, and other relevant cultural information, from agencies such as VACCA and the Secretariat of National Aboriginal and Islander Child Care (SNAICC) Resource Service. Working in parallel with an Aboriginal Child Care Specialist Assessment and Support Service (ACSASS) worker will help gain trust and respect from Aboriginal children and their families.

Under the *Children, Youth and Families Act (2005)*, (s. 176, 283, 287 & 323), the child protection practitioner, in consultation with ACSASS, is responsible for ensuring that a cultural support plan is prepared for every Aboriginal and Torres Strait Islander child in out-of-home care and subject to Guardianship to Secretary Orders as part of their case plan.

The purpose of a cultural support plan is to ensure that Aboriginal and Torres Strait Islander children remain connected to their family, country and community and is designed to include input from the child's family, extended family, child protection, an ACSASS practitioner and other relevant professional and community members.

Child protection practitioners must involve an ACSASS practitioner in making the assessment when working with Aboriginal and Torres Strait Islander children. Cultural support plans are legislatively required (s 176 91) when an Aboriginal and Torres Strait Islander child subject to a Guardianship to Secretary Order or a long term Guardianship to Secretary Order is placed in out-of-home care.

The Aboriginal Child Placement Principle has been enshrined in legislation in Victoria (s 13), and throughout Australia. The principle outlines a hierarchical order for placement options to be considered for Aboriginal and Torres Strait Islander children. The priority is to place the child within the Aboriginal extended family. If this is not possible, an Aboriginal family within the child's community near the child's family should be considered. If neither option is possible, an Aboriginal family outside the child's community should be considered. Finally, as a last resort, the child may be placed with a non-Aboriginal family living near the child's family.

Children from culturally and linguistically diverse families

Families from overseas arrive in Australia with a wide range of backgrounds and histories, for a variety of reasons, and with varying English-language competencies. To be able to communicate successfully with these families and have the best interests of the family at heart, several factors need to be considered. For example, a level of proficiency in English assists in everyday tasks, however it may not represent understanding of the Australian culture and Australian laws in regard to child protection. Practitioners also need to be careful not to assume shared understandings of what family support and child protection means.

Research indicates that the safety of children in culturally and linguistically diverse (CaLD) families may be compromised because practitioners lack a comprehensive understanding of the diversity of families involved (Gilligan & Atkar 2005; O'Neale 2000).

Cultural differences in child-rearing

A key skill in working with families from a CaLD background is determining what constitutes culturally unfamiliar child-rearing practices as opposed to child abuse (Kaur 2009).

Some cultures tend to be highly individualistic while most families from a CaLD background in Australia have been living in societies that have a high reliance and interdependence on community and extended family (Sawriker & Katz 2008). Parenting styles may differ between those that are familiar to CaLD families, such as communal parenting, and the more nuclear family style of most Australian families. For example, in collectivist cultures, children under 6 are more likely to be consistently looked after by older siblings and grandparents.

These differences need to be clearly in mind when assessing protective concerns. Cultural consultation is crucial so that we avoid the mistakes of minimising concerns or, on the other hand, conducting rigid and unfair assessments that are judgemental and disrespectful of cultural differences.

Cultural differences about families and parenting need to be clearly held in mind when assessing protective concerns. Consulting with cultural experts or community elders is crucial to avoid the mistake of minimising the concerns or conducting rigid, unfair assessments. The key questions to keep in mind are: Is the child safe? How well is the child developing?

Refugee families

Refugee families face a multitude of issues, many of which can impact on child wellbeing, and these issues, such as traumatic experiences in their country of origin, migration processes, and difficulties in adapting to a new culture, may bring the families to the attention of child protection services (Arney & Scott 2010). Many refugee families may find it difficult to adjust to a society that prioritises the parental role over communal parenting approaches with which they may be more familiar (Arney & Scott 2010). Immigrant and refugee families might be reluctant to share information with workers because of issues such as a mistrust of authority, fear that they will be misunderstood (Sawriker and Katz 2008) and fear of deportation (Kaur 2009).

Refugee families often experience long-term separation and loss of family members. Families may have spent many months or years in refugee camps in an unfamiliar country. Traumatic experiences may impact on the ability of parents to engage in 'normal' parenting roles. In some cases, this may mean that other children in the family take on the parenting role.

Working with CaLD and refugee families

Suggestions for practitioners who are working with CaLD and refugee families include:

- Reflect on the cultural beliefs, attitudes and knowledge that you bring to the workplace.
- Acknowledge that each culture, family and individual is different and comes with a unique experience (Arney & Scott 2010). This may include traumatic experiences affecting the current functioning of the family or its members. Seek to understand the individual experience of each family and family member. Remain open and respectfully curious and empathic about the families' experience.
- The more accurate knowledge that practitioners can gain about the cultural background of a family, the more positive the outcomes for that family (Kaur 2007).
- Religious and cultural beliefs of the family need to be respected and family members need to be encouraged to discuss their beliefs openly (Yeo et al 2001).
- Engage in consultation with professionals with expertise in working with refugee families (Arney & Scott 2010).
- Develop links with elders and community leaders (Armstrong 2010).
- Provide information in a range of languages. It is important that accurate information is being provided and fully understood because misunderstandings lead to frustration and embarrassment.

The use of interpreters

Appropriate recognition of language and cultural issues can help to ensure that working with CaLD families is a positive experience for all. The use of interpreters can help to prevent misunderstandings, which can also be considered a social justice issue (Brophy 2003).

Points for using interpreters include:

- If there are any concerns about the child's welfare, the child must have access to an interpreter (Kaur 2007).
- If a child's first language is not English, an interpreter should be present. This should be considered for key interviews even when the child is confident speaking English. At the time of the event, the perpetrator and the child may have used a different language, meaning that the description of events can be very different in the child's native language and he/she may not know the equivalent English words (Fontes 2005).
- If both parents' involvement is suspected in the abuse, or conflict or misunderstandings arise, parents ideally would be interviewed separately by different interpreters (Thoburn, Chand & Procter 2005).
- Always use trained interpreters rather than relatives, partners or children.
- If there are issues of confidentiality, such as when an interpreter is a community member, an interstate interpreter should be used (Arney & Scott 2010).

- The presence of a male interpreter may make it more difficult for women or girls to discuss sexual or medical matters (Thoburn, Chand & Procter 2005). Gender sensitivities may also need to be considered when interpreters are interviewing boys and adult males.
- It is important for practitioners to address the client, not the interpreter, and develop the relationship with the client (Arney & Scott 2010).
- Interpreters should be booked where possible to allow adequate time for meetings and interviews (Thoburn, Chand & Procter 2005).

Within some cultures, it is important to remember that there is an emphasis on addressing problems within the family, and problems are not generally shared with outsiders (Arney & Scott 2010; Sawriker & Katz 2008). As a result, families from a CaLD background are less likely to seek extra-familial help, and may also view involuntary involvement of services as interference (Arney & Scott 2010).

When engaging with different cultural groups remember that your warmth, practical assistance, respect and transparency are powerful engagement tools. Families will sense your genuineness and begin to trust your integrity when they experience you following through on promises of help. Be culturally sensitive and seek advice from appropriate professionals.

Practice tool

Children and their families

The aim of this tool is to provide some additional guidance about specific things you might consider when working with children and their families.

Information Gathering

Engaging the family

The first step in working with a child and his/her family is to 'join' with the family, build rapport and a working relationship. The wise use of your authority is crucial. The following points may help:

- Position yourself respectfully and convey a sense of empathy towards the experience of *each* family member, including siblings and extended family.
- Combine warmth with transparency about your role and the reasons for your involvement.
- Be upfront about any limitations you have, such as time constraints.
- Issues of confidentiality need to be explicit, including the process of sharing information if necessary.
- Don't presume to 'know'. Ask, listen, listen harder to what is not being said, and then paraphrase, checking that you have understood correctly. Explain why you are taking notes if you need to record details.

Engaging families is crucial. Initial engagement is often fragile, and practitioners may need to spend some time 'earning their stripes' before gaining the trust of families. Elements of successful engagement with families include the worker demonstrating:

- a genuine commitment to being a helpful resource
- being 'down to earth'
- avoiding jargon or an officious tone
- finding something to like about the person and getting to know them
- that the issue is about the child, not a power struggle.

Deliver what you promised – concentrate on addressing key physical or practical needs first, such as getting the fridge fixed or paying for school camp (Miller 2009). It makes sense that families will be unable to concentrate on the bigger issues until basic needs are met. From there, 'talking about the talking about' painful experiences will help to create safety for the family when discussing traumatic events (Miller 2009). That is, acknowledge that the conversation is difficult. Wherever possible, check with the family members about how the conversation can best take place. Flag with them that you would like to be upfront, so that parents can prepare themselves and engage with the process of discussing concerns and 'bottom lines' about what needs to change for the sake of the children.

Where information exists in a protective intervention report that a child may have sustained harm from physical, sexual abuse or serious neglect, child protection must contact the Victoria Police (Sexual Offences and Child Investigation Team – SOCIT) before contact with the child/parents in order to jointly plan the investigation. Where child protection becomes aware during an investigation that a child may have suffered sexual abuse, physical injury or serious neglect, the matter must be reported to the police as soon as possible. Refer to the protocol between Child Protection and Victoria Police for further details.

Once rapport is built, the practitioner can start to gather information on the child's history, present circumstances and future protective and risk factors. Information gathering is a dynamic, incremental and ongoing process as the child and family's situation changes over time. Key domains for consideration and key questions and prompts are provided in the Best Interests Case Practice Model Summary Guide. The following pointers for information gathering summarise the important questions and prompts.

Document a comprehensive history

- Read the file! History matters – it is essential in forming your risk assessment and judgement about the likelihood of harm recurring. Past trauma is often triggered and played out in the present. You cannot understand children's current behaviour without understanding their lived experience, health, developmental and family history, including sibling history. Preparing a genogram or family map with a child can be a useful tool to do this. Refer to the Child and family snapshot tool at the back of this guide which will assist you in constructing a family genogram.
- Who has had the most consistent relationship with the child?
- With the help of the child and family, create a timeline of where they have lived, key events, and other important milestones.
- Record a comprehensive family, health, developmental, childcare and educational history for the child and siblings from infancy to the present. Interview family members, past carers, workers and teachers where possible. Significant information may have been lost or inaccurately recorded, or be absent because no one has yet developed a thorough family history.
- Summarise the file according to type, frequency, severity, source of harm and duration, as well as demonstrated sources of protection available (Bromfield & Miller 2007). Recent research indicates that events after an adverse experience are at least as important as what happened at the time (Rutter 2006).
- Has there been previous involvement with the child, his/her siblings and/or parents? What was the outcome of previous interventions? Is the previous practitioner contactable?
- Seek information from other sources. Have other services or organisations been involved? For example, what role has the school played in the past with bullying behaviour, or school refusal?
- Describe the child's diet? Does it contain adequate nutrition, now and in the past? What is the potential impact of diet on the child's behaviour?
- Incorporate all of this information into the file notes.

A comprehensive history will alert you to the effects of cumulative patterns of harm on a child's health, safety and development – a requirement in the *Children, Youth and Families Act (2005)* (s. 10(3)(e)). For guidance on recognising, assessing and responding to cumulative harm, refer to the Cumulative Harm specialist practice resource.

Establish the developmental impacts

The next step is to consider the impact of past events on development and the meaning of this impact.

- At what point have past adverse events impacted on the child's health and development, and in what ways? For example, prematurity or failure to thrive in infancy, ongoing family violence, parental mental health issues, or a series of placements may have influenced the child's ability to form strong attachment bonds with adults.
- What age and stage of development is the child at now? Is the child functioning at or below an age-appropriate level for various developmental tasks?
- What are the developmental impacts on the child's learning and education, and in terms of participation and friendships?
- Are there loss and/or grief issues? For example, abused children may feel a loss of parents or family, innocence, faith in themselves or others, material losses such as homes or schools and hopes for a normal future.

To assist with your assessment, refer to the [Child Development and Trauma specialist practice resource](#).

Family and other connections

- Who 'surrounds' the child, and what is the nature of the relationships? Are they age-appropriate relationships? Is the child isolated? Is he/she supported? Draw a genogram, ecomap or sociogram to help the child and family identify those who are close to the child (whether family or not), and who is aligned with whom.
- If the child's parents have separated, explore both sides of the family.
- Practitioners often overlook siblings when they can hold vital information and ideas about solutions and leverage for change. Always think 'family', and explore relationships between siblings and other family members.
- Explore school peer group, sporting, cultural and community connections. Be curious about the child's sense of competence in the world. We might be judging him/her to be the 'parentified' child (where there is a reversal of the role of parent and child), however he/she may have a sense of pride and competence demonstrated in cooking for a mentally ill parent, for example, or that he/she interprets for a non-English speaking parent. Understand the child's perspective and don't assume to 'know'.
- Are parents or caregivers offering adequate care by being aware of and responding to the child's developmental, educational, social, emotional, recreational, nutritional and medical needs? Is the child in a recognisable routine?
- What are the communication patterns in the family? What are the repeating behavioural patterns? Who says or does what, to whom, and when? And then what happens?
- Are there consistent rules and consequences of behaviour in the family or placement? Are parents' or caregivers' responses to the child's behaviour based on misunderstanding, frustration, ignorance or anger, and if so, are they responsive to suggestions?

- Are family members involved, disengaged from or emotionally enmeshed with one another? What are the transgenerational patterns, for example, are there positive patterns such as nurturing grandmothers caring for children or repeating adversities such as family violence, adolescent pregnancy or alcohol abuse?
- What is the child's experience within his/her sibling group? As a practitioner, remain astute to the possibilities to strengthen these relationships.
- How is the child presenting and performing at kindergarten or school? Going to school is a huge developmental step for children and of major importance to them, as well as being a major source of information about the child and source of safety. It is usually the first place where outsiders notice indicators of abuse such as concerning child behaviours. A good resource is the Calmer Classrooms literature (see the resource section at the end of this publication for further information).

Current behaviours

Once a developmental, social and family history is established, as well as an understanding of the impact of these events on the child's development and wellbeing, current behaviours can be better understood and contextualised. This information is vital when forming your assessment and planning your intervention. Previous attempted solutions need to be explored so that you don't make the mistake of repeating an intervention that has already failed.

- What is the child telling us through his/her behaviour?
- Which current behaviours may impact on the health and wellbeing of the child (or others)? Explore different hypotheses as to why the behaviours are happening, paying attention to externalising (challenging, hyperactive, hyperaroused) and internalising (depressed, withdrawn) behaviours. Are any behaviours escalating?
- Does the child have age-appropriate opportunities to develop responsibility for decision-making and increasing autonomy or self-reliance, within the context of supervision, nurturance and acceptance? Explore whether the child is overburdened with adult responsibilities or 'parentified', that is, a reversal of the role of parent and child.
- What are the child's strengths? (see Resilience and Strengths, p.xx)

Current behaviours can be better understood and contextualised when the developmental, social and family history of the child is understood, as well as the impacts on a child's development. This information is vital when forming your assessment and planning your intervention.

Assessing for disability or developmental delay

Basic questions to assess whether a child in contact with the child protection system has a disability or developmental delay, and the extent to which this has a relationship with the abuse or neglect include (Kendall-Tackett, Lyon, Taliaferro & Little 2005):

- Does the child have a disability or developmental delay, and if so, what is the nature of the disability or delay?
- How severe is the disability or delay?
- Does it interfere with activities of daily living?
- What was the age of onset of the disability or delay?
- Did the disability or delay pre-date the maltreatment?
- Was the disability or delay clearly a result of maltreatment?
- Has neglect, family violence or other factors contributed to a developmental delay or disability?
- Did the child require an out of home care placement? And was the placement able to respond to the child's disability or delay? **Did the child make any developmental gains while in placement?**
- What assessments have been completed? Is there an up-to-date paediatric or other specialist assessment and intervention plan? Is the child linked into available specialist services?
- What specialist resources are required and can be sourced for the child and family?

Communicating with children – some general tips:

Before you interview children, wherever possible engage the non-offending parent first. This will enable the child to engage with you more easily and feel that he/she has 'permission' to speak. Even where there are allegations of sexual abuse, the initial engagement of the mother usually enables better outcomes in the interview process and in the healing and recovery of the child. *This section gives general tips and suggestions, however the following section, beginning on page XXX, gives clear directions about the process of formal forensic interviewing techniques.*

The context for the interview is also important. Many important interviews with children have occurred in non-formal settings, such as at the park, on the swings, walking or throwing a basketball. Driving in the car is a classic setting where children can feel safer to open up. The child has a greater sense of freedom and control over the pace of the conversation, eye contact is less intense, and there is a sense of warm containment in a car, all of which is helpful to put the child at ease (Miller 2009). A key ingredient is that you relax enough to put the child at ease and that you enjoy talking to him/her.

1. How will I start? Build a relationship that leads to engagement in change.

Sit at the same level as the child. Have paper and coloured pencils handy because some children prefer to show and draw rather than tell, or draw as they tell. For example:

- Can you draw me a picture of your family?
- Can we do a family tree together so I can learn about your family?
- If you had three wishes to make things better, or a magic wand, what would you choose?

Sitting side by side and focusing on the paper can free some children to engage in a more relaxed way about who is who in the family.

- Let the child be the expert of his/her own world – it may help to consider initially working from a ‘one-down’ position, that is, the worker as student. Remain open and curious.
- Be creative. Children can be interviewed when sitting in a park, a cafe, the backyard, walking, patting a dog, sitting outside, driving in a car or hiding under a table. Movement, scenery, companionship, containment and/or the need for limited eye contact are often a great invitation to communicate. Imagine you are both sitting on a pier fishing. Now have the conversation.
- Be clear about your role and the reasons you are involved, but also talk about normal ‘safe’ things, such as school or activities they like. Enjoy getting to know the child.

2. How should I ask questions? Delivery.

- Honesty and straightforwardness is appreciated and appropriate. Respond flexibly and adapt to the verbal and non-verbal cues from the child:
- Be open-ended in your questions, for example: ‘Tell me everything you can remember about what happened’
- Help the child have a sense of control about the timing and pace of difficult conversation.

‘We need to talk about what happened – where would be a good place to talk?’

‘Tell me if I got it wrong.’

‘This seems hard to talk about.’

‘Is it okay to tell you what I’m thinking?’

‘The look on your face says that 10 minutes of this conversation is enough and then we’ll get a milkshake – deal?’

- Avoid using jargon or long words.
- Negotiate where you can, but be clear about bottom lines.

Based on their practice experience, Miller and Dwyer (1997) highlighted the importance of creating a safe process, so that children feel more comfortable discussing difficult or embarrassing events. Helping children visualise a safe place that they really like, and to draw what they would see, hear, touch, smell or taste there, can be a useful way to engage them, and to return to if they find the interview process stressful. Managing the pace of the interview and tuning in to the child's emotional state by observing his/her non-verbal cues are key interviewing skills.

However, the ideas presented below should be implemented sensitively only at a point in the interview where you have built rapport and there is clarity about your purpose. Children need to be made to feel comfortable and sense that you understand how difficult and confusing the process may be for them. Normalising the conflicting emotions they may be experiencing is helpful for children and allows you to be more informed about their overall experience. For example:

- The interviewer openly reflects in the presence of the child that '... some things are really hard (scary, embarrassing, weird, funny) to talk about ... what do you think would make it hard for an eight-year-old to talk about stuff?' The interviewer then sits side by side with the child and starts to jot down on a piece of paper (or a whiteboard) the 'good things about talking' and the 'bad things about talking'. Alternatively, the child could draw his/her ideas.
- Then ask the child what would help an eight-year-old to get rid of the 'bad things about talking'. For example, if his/her fear is about 'getting into trouble for talking', you will need to make sure that the parent/s or carers are supportive and the child is reassured that talking is a good thing to do. Consult your supervisor or experienced colleagues if you are feeling stuck. This process helps the child to feel that you are 'safe' and that you want to understand his/her experience.
- Try not to ask direct questions – use observations and give space for the child to respond.
- Paraphrase and reflect back to earlier parts of the conversation where the child has shared information.

It sounds like you're saying:

'Sounds like school's been pretty hard lately ...'

'Seems like you find yourself in trouble all the time.'

'Seems like it's really confusing ...'

3. What else may help? Technique.

- Use existing props in the room, or non-verbal cues to answer questions.

Use arm gestures to show/guess how big the 'sad/angry/confused' feeling is.

Ask children to show you on the wall where the feelings would come up to, or (for example) how much of the room their anger would fill up. Encourage the use of drawing, poetry, story writing or movement to enable the child to externalise what has happened.

- Playdough can be useful at times for showing or modelling family events or as a soothing device to squeeze when children are talking about difficult things.
- Similarly, things such as playing a game, taking a break, eating a snack or getting a warm drink can help the child manage the intensity of the session.
- Work out with the child his/her signal for when a break is needed. Follow through and honour the signal so that you build trust.
- If the child has a disability, determine the ways in which he/she is most skilled and comfortable in communicating, and seek support if needed. See p.xx for more detail on this issue.
- Use specially designed cards such as St Luke's strengths cards and bear cards. Children can choose one to describe how they felt or (for example) how they think their brother felt.
- Celebrate birthdays and other special events in the child's life, but remember that anniversary times may be particularly sad and difficult. Predict and prepare for this by having open conversations with the child, and increase support at these times.
- Let the child know that you like him/her. Find things to like!
- If children's behaviour is difficult or rude towards you, let them know you will 'hang in there' because you don't expect them to trust you straight away. After everything that has happened to them, why should they? However, let them know that you expect to be treated decently; reflect openly about the bottom line of respect and what that looks like. **However, sometimes using distraction and ignoring the bad behaviour is the most effective response immediately.**
- Use humour (not sarcastic) and alternate with playful breaks. Use some of the sheets at the back of this resource that are child friendly.
- If you are transporting the child, play car games, or sing songs, tell stories, and stop for regular breaks.
- Don't be afraid if you have strong emotional responses. Talk about these responses in supervision so that you are supported and so your emotional responses can inform your practice, and not overwhelm you.

Forensic interviewing of children

Children should not be interviewed by child protection without the prior knowledge of the parents other than in exceptional circumstances. Where an interview occurs without the parent's prior knowledge, the parents should be informed as soon as possible. To reduce the need for the child to be subjected to multiple interviews and interviewers, careful planning should take place with police where appropriate (see protocol between Department of Human Services and Victoria Police) and joint police/child protection interviews arranged.

Many things will influence the capacity and ability of a child to engage meaningfully in a forensic interview. The amount of information a child reports is likely to increase with age, but memories will vary according to factors such as the:

- type of event experienced
- time between the event and the interview
- information that needs to be recounted
- conditions and context under which an interview is conducted, including the 'socio-emotional atmosphere' and use of language
- clarity of the memory
- influences that occurred after the event (Daniel et al 1999)
- age of the child at the time of the event and interview.

Several child interview protocols are in use. Many have a number of similarities and the following five stages are common to standard interview protocols. Importantly, it is unlikely to be useful to conduct the entire process of disclosure in one sitting.

Disclosure is a process and usually does not happen on the first visit, especially if it is in a stressful place or circumstance. Most people take a couple of sessions to feel comfortable and will generally disclose more information and details of the abuse over time. Give the child the chance to have breaks and a play if he/she wishes to, during the process.

1. Introduction and establishing rapport

- Introductions should be conducted in a relaxed, child-centred manner. Children should be introduced to anyone they don't know, and be given time to familiarise themselves with their surroundings. Make sure the child knows where the toilet is, and is given a drink and snack. Have drawing materials and create a child-friendly environment.
- Ensure that the child has a developmentally appropriate understanding of the role and responsibilities of child protection practitioners as protective interveners.
- Explain why one practitioner will be taking notes if that is intended, and be prepared to explain confidentiality (if required).
- Establish whether the child knew you were coming and what he/she had been told, by whom.
- Make sure the child doesn't feel isolated or trapped. Use commonsense to determine what the child needs in terms of limits. A child may need permission to leave the room if he/she wishes, and find a trusted adult or go to reception. Other children may need to stay in the room and understand that you are able to provide safe and clear directions about their behaviours and the interview process.
- If a parent or carer is present and the child is acting out, observe their response to the child. If they require help with the child's behaviour, gently coach the parent to respond appropriately.

- Establish the boundaries of the interview, for example that the child is not permitted to hurt him/herself, the practitioner or any property. Make sure that the child understands early in the session why he/she is there, and what to expect to the extent possible.
- Any professionals involved in the interview should, in age-appropriate terms, describe their roles to the child. It can be effective to explain that their work involves:
 - talking to children who can be sometimes happy or sad
 - making sure children feel, and actually are, safe
 - being a good listener for children
 - taking very seriously what children have to say (Davies & Townsend 2008).
- Allow the child time to talk freely about him/herself in the rapport phase and engage in a casual conversation with the child. Ask the child to tell you about favourite things, what he/she likes to do, different games he/she likes to play and interests. Follow any cues and gently paraphrase what the child is saying. Convey a sense of enjoying the time with the child and that you are genuinely interested in him/her.

A number of resources are available that can help you build rapport and trust with a child. An example of Practice Tools For Working With Children worksheets on pages xx-xx that can help the child to communicate with you are provided at the back of this publication– together with further resources and links to useful websites.

It is important not to skip or hurry through the rapport phase; building a relaxed and trusting connection between interviewer and the child is the foundation of a good interview. As Wilson and Powell (2001, p. 47) observe, ‘... any amount of time spent building rapport is likely to pay off later in terms of the amount of detail the child will subsequently provide. This is because the more comfortable the child is within the interview setting, the more information he is likely to share, particularly information that is perceived to be traumatic or embarrassing’.

‘Building rapport requires listening to what the child wants. In short, if the child wants to chat, then chat. If the child wants to talk, then listen.’ (Wilson and Powell 2001, p. 47)

2. Establish ground rules

Encourage the child to say if they don’t understand a question:

‘If you don’t know the answers to my questions that’s okay’

‘If you don’t understand a question, tell me and I will ask it another way’

‘If you need to go to the toilet or need a drink, tell me and we can do that’

‘Use whatever words you want to’

Work out with the child beforehand how they will say, for example: ‘I don’t get what you are saying!’

3. Introduction to the topic of concern

Once rapport between the interviewer and the child has been established, it is time to start talking to the child about the purpose of the interview (for example, the alleged abuse). Wilson and Powell (2001) suggested that one of the best ways to instigate this conversation is to ask the child directly: 'Do you know what you have come here to talk about?' (p. xx). If the child does not know why the interview is being conducted, the interviewer should mention the event or concerns that necessitated the interview. How this should be done depends on where the initial report or indicator of the concerns came from. This may be something the child has said, an adult's suspicion, physical indicators such as sores or bruises, or a change in the child's behaviours (Wilson & Powell 2001).

Care should be taken to avoid leading questions and to ensure the name of the reporter, or any information likely to lead to the identification of the reporter, is not disclosed

4. Eliciting a free narrative account

The free narrative phase is the most important part of the interview, where it is the child's turn to speak. As Davies and Townsend (2008) argue, this is the point at which children can provide an account of the facts using their own words and at their own pace. A broad consensus exists among researchers that allowing children to convey events in their own words and with as little prompting from the interviewer as possible is the most effective way to elicit a reliable account of past events (Powell & Snow 2007).

Calm and attuned warmth should be conveyed towards the child, without being cold or neutral, or 'gushy' and emotive. The practitioner needs to convey a sense of empathic listening so that children experience someone bearing witness to what they have experienced or suffered, without shutting them down or leading them on.

The free narrative phase of the interview generally begins with the interviewer asking broad, open-ended questions. There are several reasons why responses to open-ended questions are often more informative than those to narrower or more specific questions (Snow & Powell 2007):

- Responses to open-ended questions are usually more accurate because the process of memory retrieval is less influenced by external factors (for example, leading questions).
- Open-ended questions offer children the chance to collect their thoughts and to explain events in their own terms, which promotes more detailed memory retrieval.

An initial open-ended invitation could be:

'Tell me everything you remember about what happened from the beginning to the very end. Try not to leave anything out even if you think it is not important.'

An open-ended breadth question could be:

'What happened then ..?'

'What else happened when ..?'

An open-ended depth question could be:

'Tell me more about the part where ...'

'Tell me everything about the part where ...'

Minimal encouragers are ...

'Uh huh'

'Mmmm'

'Aha'...

and repeating the last few words of the child's last sentence.

- Specific questions can allow children to mask language limitations, because they often require only a single word or single sentence response.

A child can also more easily guess the answer to a question that can be answered in one or two words (that is, a closed-ended question), increasing the likelihood of the answer being wrong (Toth 2011).

Tips for obtaining free narratives from children

Here are some tips for obtaining free narratives from children:

- Patience, tolerance of silences and the ability to refrain from interrupting when a desire for detail arises are required to encourage free narrative (Wilson & Powell 2001).
- If children do not respond to the request for their account of events, it is often very helpful to return to the rapport phase of the interview for a short time before again attempting to elicit a free narrative (Davies & Townsend 2008).

- It is important to avoid specific questions while children are engaged in a free narrative because these tend to stop the flow of the narrative and can lead to important information being missed. It is best to make notes of specific questions and ask them later in the interview (Wilson & Powell 2001).
- It is good to encourage children throughout this process with non-verbal or short verbal cues, such as gentle nodding, or by saying 'uh huh', 'mmm' and 'oh' (Wilson & Powell 2001).
- Excessive praise or encouragement through this phase of the interview should be avoided, because this can indicate that the interviewer has pre-established ideas about any alleged past events (Davies & Townsend 2008).
- If possible, avoid asking questions that children can answer with 'yes' or 'no' (for example, 'Did you go home after that?'). Children can interpret such questions as a cue that the interview is finishing. It is better to ask questions that require further information from children (such as, 'What else happened?', 'Tell me about that') (Wilson & Powell 2001).
- 'Active listening' is applicable to this phase of the interview to show the child that the interviewer has heard what the child has said, while keeping the interviewer's influence to a minimum (Davies & Townsend 2008). The interviewer may reflect back to the child what he/she said without demonstrating through voice tone approval or disapproval. The interviewer may then offer support for the child to proceed further, without interpreting the statements.
- It is essential to use the same terms as the child for parts of the body or other objects. For example, children may refer to their own or others' genitalia with terms such as 'privates', 'winkey', 'rudey', 'fanny' or 'willy'. If children are corrected when they use such terms, they may feel that they are making mistakes or 'getting things wrong', and this can hinder the interview.
- Children should not be forced to point to their own or others' bodies to illustrate a point they are making. However, younger children will often point or spontaneously show you what happened. Do not stop this process because young children are often more comfortable showing than telling. Stay calm and attentive and continue to explore the child's experience.
- Disclosing traumatic experiences can be very difficult for anyone, children included. If children are obviously finding the disclosure of trauma painful, they should be allowed or encouraged to divert to a less painful subject for a time, before returning to talk about the trauma directly. It can be helpful to engage children with the drawing activity of the safe place, as described earlier, and giving them time to take a break from the intensity so that you can re-engage when ready. If children become fearful or teary, remain calm, warm and patient with them. Explore gently what they are feeling or thinking and paraphrase and reflect this back. Leave silence and room for them to enlarge on their previous disclosures.
- Later, reassure them that it is really normal to feel like this, given what has happened to them. Some children can become triggered into highly aroused and anxious states and act out abuse and violence with toys or other objects in the room. This re-enactment is very important information, but you should manage it sensitively so that everyone is safe. If you can, help children express what happened and what they were feeling in words.

5. Specific questioning

When children have completed their free-narrative account, the interviewer can then proceed to ask any specific questions that may fill in gaps in the narrative, clear up any inconsistencies and clarify details. Specific questions can normally be answered in a few words (such as, 'About what time did this happen?', 'Where was your brother when this was happening?', 'What did you mean when you used the word "ickey"?', 'You said he took you to a movie. What was the movie about?').

Many children have difficulty answering questions that begin with the words how, when and why, because such questions often lack specificity and can require sophisticated abstract reasoning (Davies & Townsend 2008). Children tend to more easily comprehend questions that begin with where, who and what. Some examples of such questions include:

- Where did you go next?
- Who was there when you got there?
- What did it feel like?
- What was he wearing?

Although specific questions are often an important part of the interview process, they should, in general, be kept to a minimum. Children are more liable to make errors when asked these questions as opposed to more open questions. For example, some children may not fully understand the question and will make up an answer simply to please the interviewer (Wilson & Powell 2001). If you are unsure, ask the child to draw or show you.

When children come from other cultural backgrounds than yours, be aware that some questions and some responses may have different meanings in some cultures. For example, a child may answer 'yes', regardless of the correct answer, because it is more respectful to agree with the interviewer.

6. Closure

It is important to ensure that the interview is finished appropriately, because closure of the interview can have a strong impact on children's overall perception of the process and their willingness to engage in future interviews. The closure phase of the interview should involve:

- The interviewer summarising the 'headlines' of what the child has talked about. This allows the interviewer to check with the child that the interviewer has understood everything correctly.
- The interviewer should thank children for their involvement and allow them to ask any questions or air any worries that they might have or think their mum, dad or siblings might have.
- The interviewer should provide contact details to children and their caregiver and encourage them to make contact if they have any further questions or concerns.
- Be clear when will be the next time you will ring or see them.

Four messages that practitioners can give to children when they talk about the tough stuff (Moore & Layton 2010):

- I believe you.
- You did the right thing by talking to a safe adult.
- It is never okay for kids to get hurt.
- I promise that I will get back to you and let you know what will happen next.

After the interview

It is of critical importance that children know that you will manage the process of sharing the information they have disclosed with parents, carers, school, police and others in safe and sensitive ways. In the closure phase of the interview, don't promise to keep information secret, but give the child choices where you can, about how and when others will be told and what words will be used. Other points to consider after the interview:

- Building and keeping the child's trust is key to obtaining good quality information and how you manage the process may determine the child's healing and willingness to trust other adults in the future.
- Never trivialise the child's fear or use sarcasm.
- Help children reconnect with the 'here and now' and what they have to do after the interview. Gently reorient the child into the next phase of the day.
- If it is safe, talk to the parent or carer about how the child is feeling after the interview and, ideally with the child present, the headline issues of what was discussed. Supporting the carer with managing any reactions is of critical importance. Children may need to play or have some time out before returning to school or home, or alternatively may need immediate re-immersion into their routine activities.

Each child will be different so ask a parent, carer or teacher who knows the child well what they think the best strategy will be to help the child reintegrate into everyday activities after the interview. Check out what has worked best in the past. Ask the child what he/she needs to do now.

Communication with children, especially those who have experienced trauma, takes practice. In addition to specific training, such as interviewing children about sexual abuse, other suggestions for skill development are: co-working with senior practitioners, role playing some of these techniques in team reflective practice sessions, and using supervision before and after the interviews.

Communicating with children who have intellectual disabilities

It is often assumed that a child with a disability is not capable of providing credible information in formal or forensic interviews, but this assumption is not borne out by the research evidence. For example, Henry and Gudjonsson (1999, 2003) found that, when asked open-ended and specific questions, children with intellectual disabilities were able to provide information that was as accurate as that provided by non-disabled children of their developmental age equivalent.

For forensic interviews with children with an intellectual disability or cognitive delay:

- Gather information before the interview begins on their capabilities and any special needs they may have. Check with parents, carers or teachers about what is the appropriate pace for the interview, and any other strategies that may help. Ask if there are any other issues that may affect the child at this point in time. Do not assume that the disability is the cause of any problems – it might be a fear of retribution or that the child is sick or hungry.
- Establish an understanding of children's language comprehension and ability to verbally communicate during the rapport phase of the interview. An easy way to do this is to ask some simple open-ended questions about a neutral or unrelated topic, such as 'How did you feel when that happened?' or 'Tell me what that means to you' (Anderson & Heath 2006).
- Allow as much time as children need to understand or answer questions, and allow them to respond in whatever way they find most comfortable. It is very important that the interviewer is patient (Wilson & Powell 2001).
- As with all children, use open-ended questions because such questions quickly highlight any misunderstandings and elicit the most accurate information.
- Reassure the children that it is okay to say 'I don't understand' or 'I don't know the answer to that question' (Anderson & Heath 2006). Research has demonstrated that people with intellectual disabilities tend to be more likely than others to answer 'yes' to questions that they do not understand or do not know the answer to.
- Ask the child regularly if he/she needs a break. Children with a developmental delay are likely to become fatigued or overloaded by the interview process more quickly than children who do not have a developmental delay (Wilson & Powell 2001).

Non-accidental injury

Deciding whether an injury is a result of abuse can be stressful for the family and the professionals involved, and requires careful consideration and collaboration.

The forensic evaluation of injury requires medical training and skill in order to provide an injured child with an accurate diagnosis. Abused children require a medico-legal report that will withstand the rigours of cross-examination.

When suspicion arises that a child might have been injured as a result of abuse and neglect, then child protection practitioners can consult with the Victorian Forensic Paediatric Medical Service to obtain advice about injury interpretation. Remember that there are a number of medical conditions that might be confused with abuse and children are commonly injured as a result of accidents. When in doubt about the cause of an injury, consult the Victorian Forensic Paediatric Medical Service. Phone **1300 66 11 42**

The following information about bruises and other injuries is provided in order that practitioners might be alert to the types of injuries that should generate suspicion about child abuse and neglect.

Bruising is common in active healthy children, however bruises are also a feature in children who have been abused.

Bruises in infants who are not mobile are highly unusual and should be cause for further investigation

Bruises are rare in infants before they crawl and begin to toddle around furniture, and become more common when an infant has started to crawl and walk (Sugar, Taylor & Feldman 1999). Consideration of abuse or underlying medical issues should be given where an infant younger than nine months, who is not yet mobile, has sustained bruising. Bruises in toddlers in atypical areas including the trunk, hands or buttocks should also prompt such consideration (Sugar et al 1999).

Research has found that most accidental bruises are found on the front of the body over bony prominences, most commonly the shins and knees (Maguire, Mann, Sibert & Kemp 2005).

In young children less than six years, accidental bruising to the head usually occurs in a T shape across the forehead, nose, upper lip and chin and on the back of the head (Maguire 2010). However, this may also indicate physical abuse.

Non-accidental injury and bruising

- Bruising is the most common abusive injury.
- Head and face is a common site of non-accidental bruising including cheeks and ears with a wide range of oral injuries noted (Naidoo 2000).
- Any bruising or injury to the head, particularly in very young children, should prompt further inquiry as to how the injury occurred and what medical action has been taken.
- Bruising found on children who have sustained fatal injuries are primarily on the head and face with lesser amounts on lower limbs and buttocks.
- Abdominal injuries are the second most common cause of fatal physical abuse (Collins & Nichols 1999).
- Fatal injuries can occur without bruising (Maguire et al 2005; Atwal et al 1998; Sugar et al 1999; Maguire 2010).
- Clusters (defensive injuries on upper arm, outside of thigh or bruises on trunk and adjacent limb) and/or patterns of bruises are common indicators of abuse.
- Neck, trunk, buttocks and arms are also common sites of bruising in abused children.
- One finding is clear across all studies: that multiple fractures have a strong association with abuse (Leventhal, Martin & Asnes 2008).
- Multiple rib fractures, in the absence of a history of bone disease or major trauma, are highly specific for abuse (Welsh Child Protection Systematic Review Group 2010).
- Children who are not yet walking are far less likely to sustain accidental bone fractures (Hui, Joughin, Goldstein et al 2008).
- Intentional cigarette burns are circular, about one centimetre in diameter and may occur on exposed parts of the body (Welsh Child Protection Systematic Review Group 2010).
- Be observant if the child looks underweight because some children may be deliberately starved or malnourished through neglect.
- If you observe an adult-sized bite injury on a child, or any injury where you are uncertain or where there are suspicious circumstances, seek medical advice and consult the Victorian Forensic Paediatric Service. Phone **1300 66 11 42**

Research has found that up to 50 per cent of children who had been found to have abusive head trauma had been seen by a health practitioner the previous month without abuse being recognised (Maguire 2010). This statistic highlights the need for a collaborative approach to working with health practitioners, to share and improve information they have available on which to base their assessments, and through active follow-up.

Visual examination of the child

Where physical abuse or serious neglect has occurred, or is alleged or suspected, the child protection practitioner must seek to conduct a thorough visual examination of the child.

Visual examination does not require physical contact but involves sighting the child in a good light with sufficient clothing removed to satisfy the child protection practitioner that any superficial signs of injury or harm as a result of physical abuse or serious neglect would be apparent.

- The visual examination will contribute to the assessment, leading to substantiation or otherwise of the report.
- **Parental permission is required** if any of the child's clothing needs to be removed. A visual examination that cannot be undertaken without removing clothing cannot be carried out without the consent of a parent (or the child in very limited circumstances). Legal advice indicates a child over 14 may provide consent to a visual examination which requires the removal of clothing.
- Another **independent adult should witness** the examination. This may be another child protection practitioner, a police officer, or a teacher, for example. The age and gender of the child and the nature of the allegations or report should be considered in the selection of the independent adult and in how the visual examination proceeds.
- The child's presentation and his/her understanding of what is happening should be taken into account. The practitioner should clearly and calmly explain the process to the child, even where the child is pre-verbal. **Care should be taken** to move at the child's pace, engage and reassure the child throughout this process.
- **A detailed record** of any observed injuries should be completed, including a detailed description and diagram of their location on the child's body. When conducting a visual check, be sure to carefully note the nature, location and size of any injuries such as bruises, swelling and abrasions.
- If a visual examination suggests **signs of non-accidental injury or harm** resulting from abuse or neglect, a forensic medical examination must be arranged.

A visual examination of a child is **not appropriate to investigate an allegation of sexual abuse**. Child protection practitioners do not have the necessary medical training or physiological knowledge to undertake a visual examination of a child's genitalia. If information indicates there may be physical evidence of sexual abuse, a forensic medical examination should be arranged through the Victorian Forensic Paediatric Medical Service (See page xx)

Parent or child's refusal to allow the visual examination

While practitioners should make every attempt to encourage the parent's consent to a visual examination to fully assess the risks to the child, the parents' and child's wishes as to how the check occurs must be respected.

Child protection has no legal authority to remove a child's clothing against his/her wishes or those of their parents. The police, if in attendance, may have power to enforce compliance.

If parents refuse a request by a child protection practitioner to examine the child, you need to explain the rationale behind your request and reassure them that this is part of normal practice and that you are not accusing them of being a 'bad parent'.

Sensitively try to talk through their concerns and focus on solutions and creative ways to alleviate their worries. For example, if the mother is worried that her partner will 'hit the roof' and you know that there is a risk of family violence, make every effort to engage him in the process if she believes it is safe to do so, or to conduct the interview away from the home.

The mother may prefer to bring the child to the Department of Human Services office with you or agree to a medical assessment, that you can then immediately organise. Make every effort to diffuse the stress while 'holding your ground' calmly and sensitively, on the need to make sure that the allegations about the injuries have been properly assessed – and the bottom line is that you need to visually see the child's body, and/or organise a medical assessment. You can explain the potential consequences of refusing the request. If the parent still refuses, your supervisor must be consulted and a court order may be sought, if the likelihood of harm is high and it is in the child's best interests.

This process should also be followed where a young person (14 or over) agrees to the visual examination against the wishes of their parent or vice versa.

Sexual abuse allegations

A forensic medical examination of a child who has been or is suspected of being sexually abused should be undertaken unless the child, who has been assessed as having sufficient understanding and capacity to make decisions, does not consent to the medical examination.

If medical evidence is absent, it does not prove that a child has not been sexually abused or that the child's disclosure should be dismissed.

Forensic medical examinations do not focus only on forensic evidence and may be very reassuring for the child. These examinations can help children understand what has happened to them and their body, and may alleviate concerns they may have in relation to the alleged abuse.

A forensic medical examination

This may be required at any time during the investigation and assessment phase, the protective intervention and assessment phase or protection order phase for the purpose of:

- Investigating current injuries, undetermined illnesses, unusual or obscure symptoms, or where the cause of the injury, condition or illness is undetermined, suspicious or vague, and to explore suspected abuse.
- Investigating new allegations of recent or past injuries.

- Conducting an in-depth health check including blood tests, bone scans and x-rays (where indicated as necessary).
- Medical comment on the adequateness of the parents' explanation of any physical injuries or illness.
- Medical report on the likelihood of injuries or illness being non-accidental and exploration of possible causes particularly where differing medical opinions exist.
- Assessment of paediatric development and investigation of possible causes of developmental delay.
- Documentation of injuries or illness and symptoms.
- Provision of a report and evidence (including photographic) for court.
- Providing treatment for injury or illness as well as recommendations for further medical treatment.

Medical examinations need not take place only for forensic purposes (gathering information, evidence and assignment of a likely cause), but even more importantly, may be necessary to identify any physical trauma or condition requiring medical attention and to reassure the child and parent or carers that the child is physically undamaged and unhurt or any injuries have been identified and treated.

Sometimes the forensic paediatric examination and evaluation might determine that there is an accidental cause for a child's injury or a medical condition to account for a child's condition. In these circumstances, the forensic paediatric medical evaluation might exclude the diagnosis of abuse or neglect from serious consideration.

Arranging the forensic or medical examination

In cases where criminal concerns are apparent (sexual and physical abuse or serious neglect) child protection practitioners and police must liaise regarding who should take the lead in making the arrangements for the forensic examination.

Police assume this role if the matter is suspected to be criminal, and if not criminal, but child protection assesses that an examination is required, then child protection contacts the Victorian Forensic Medical Service to arrange an examination of the child.

(Refer to the protocol between the Department of Human Services and Victoria Police where police are involved in forensic examinations).

Despite who takes the lead, it is very important that information contained in the report is shared between both parties.

The child protection practitioner or the Police need to contact the Victorian Forensic Paediatric Medical Service to discuss the reason for the forensic paediatric medical examination and to arrange the appointment.

Where a forensic medical examination is required, the child protection practitioner investigating the allegations must attend the examination to ensure relevant information is provided to the medical practitioner and immediate feedback can be obtained. However, it is generally not necessary or appropriate for the child protection practitioner to be present in the room during the examination unless there are extenuating circumstances.

Appointments can be arranged by calling The Victorian Forensic Paediatric Medical Service on **1300 66 11 42**

If the practitioner is not successful in gaining access to the above telephone number, he or she may call the **Royal Children's Hospital** on (03) **9345 4299** or **Monash Medical Centre** on (03) **9594 2155**, directly.

The process for administering requests for copies of forensic photographs has been centralised so that there is a single contact point and all requests are coordinated from this point. Following phone contact, all requests for documentation should also be made in writing. This process will ensure appropriate release of sensitive photo documentation, create an audit trail and assist in the prompt processing of requests.

In arranging a forensic medical examination, practitioners should consider:

The timing of a medical examination. If a child is presenting with an injury or is in need of urgent medical attention, a medical examination should occur at the earliest possible time. In the case of a developmental assessment or in cases involving alleged sexual abuse, more than 3-4 days prior, a more planned approach should be taken to reduce any possible distress to the child and family, unless the need for urgent assessment and treatment is indicated.

When doubt about optimal timing exists, consult with the Victorian Forensic Paediatric Medical Service and jointly plan the best time for the medical examination.

Where possible, include a parent in the process of the medical assessment. It is always desirable for the assessment to be undertaken with the child supported by the parent unless this would place the child at risk or jeopardise the integrity of the assessment.

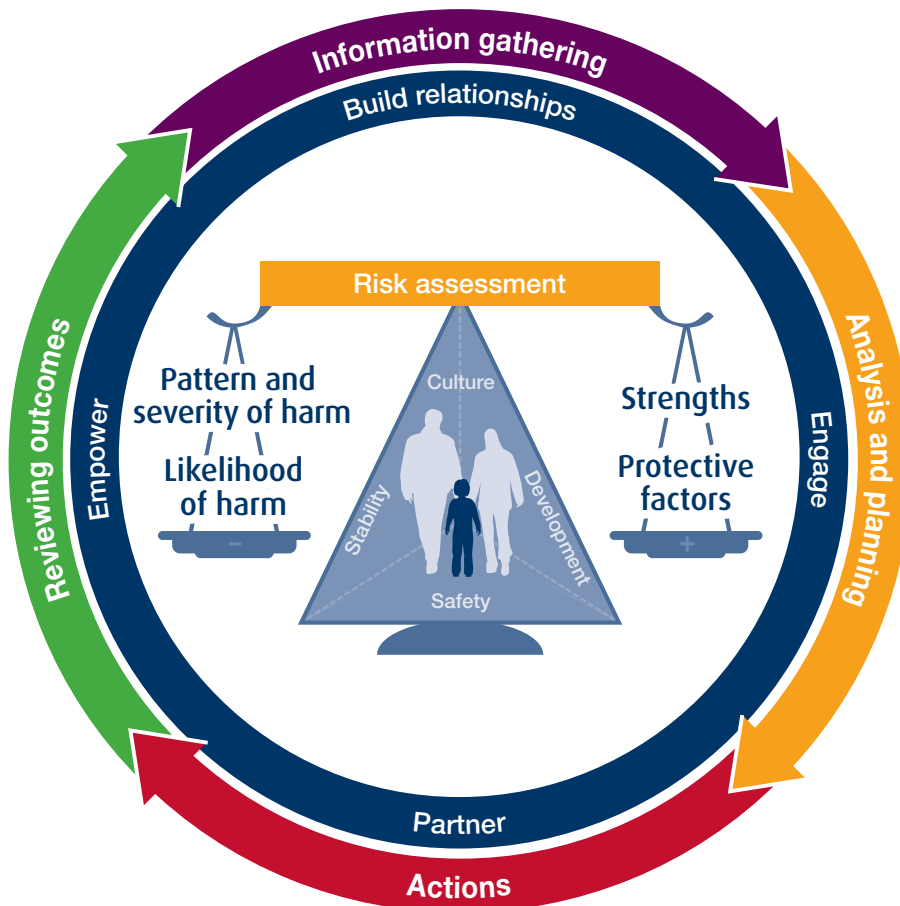
The medical examination should be planned in consultation with medical and hospital social work staff.

Don't forget the importance of:

- early contact with the relevant hospital staff to arrange the assessment
- issues of whose consent is required before the assessment can occur
- obtaining an initial provisional opinion report from the examining medical practitioner, if it is likely that legal intervention may be initiated
- obtaining the final reviewed medical report at a later stage
- issues of gender and culture
- consistency of medical practitioner, where possible.

When arranging a forensic medical examination, it is of paramount importance to ensure that medical practitioners are provided with sufficient history and background information to inform their assessment. This should include the details of previous reports and injuries that may have been unsubstantiated as 'non-accidental' injuries. Without this key contextual information, the conclusions a medical professional is able to draw, particularly about how the injury may have been sustained, are seriously limited. This will then impact negatively on the court proceedings and the child's safety.

Analysis and planning



Risk assessment

To formulate a risk assessment, you need to be a critical thinker and to consider multiple competing needs, prioritising the child's safety and development. Careful attention needs to be given to the balance of risk and protective factors, strengths and difficulties in the family. Your assessment needs to be forensically astute; and you should consider all sources of information such as observation, previous assessments, advice from all significant people and professionals. Do not rely on phone assessments or parental self report where there are suspicions of non-accidental injury, or where there have been previous concerns or offending behaviour.

Synthesise the information you have gathered about the current context and the pattern and history; and weigh the risk of harm, against the protective factors. Keep in mind that the parents' desire to change dangerous or neglectful behaviours does not equal the capacity to change; and that strengths and protective factors need to be sustained over time. The best predictor of future behaviour is past behaviour. Hold in mind the urgency of the child's timeframes for safety and secure attachment relationships. Imagine the child's experience of cumulative harm. Remember, other than the family's characteristics, the quality of the relationship you form with the family is the single most important factor contributing to successful outcomes for the child.

Characteristics to consider when assessing risk

Based on examination of file records and other data relating to over 1500 children, Reid et al (1995) identified three important organising principles consistently associated with occurrences or recurrences of child abuse or neglect for children:

1. The first and most important dimension of caregivers' characteristics that should be considered, is their prior pattern with respect to the treatment of children. The number of maltreatment events they have initiated, their severity and recency are the most basic of guides to future behaviour. In the absence of effective intervention these behaviour patterns would be expected to continue into the future.
2. If an individual believes that they are correct in their opinions about children, they will attempt to continue their behaviour so long as they are not prevented from doing so.
3. The third dimension concerns the presence of 'complicating factors', most significantly, substance abuse, mental illness, violent behaviour, and social isolation. The relevance of complicating factors is the extent to which they, singularly or in combination, diminish the capacity to provide sufficient care and protection to the child or young person.

The Best interests case practice model is underpinned by a strengths based approach that assesses the risks, whilst building on the protective factors to increase the child's safety.

Attention to safety factors within the risk analysis recognises that:

1. Both the potential for harm and for safety must be considered to achieve balanced risk assessment and risk management
2. Strengths which increase the potential for safety are evident in even the worst case scenarios and these are fundamental building blocks for change
3. A constructive approach to building safety can be taken which may be different to efforts to minimise harm
4. A strengths perspective can be actively (and safely) incorporated into what may otherwise become a 'problem saturated' approach to risk assessment and risk management

(cf. Turnell and Edwards, 1999)

Current risk assessment

Current risk assessment highlights the fact that it is made at a *point in time* and it is therefore limited and will require modification as further information comes to light. Your risk assessment should address the following key questions: Is this child/young person safe? How is this child/young person developing?

1. Given all the information you have gathered, how do you make sense of it?
Consider the **vulnerability** of the child and the **severity** of the harm:
 - What harm has happened to this child in the past?
 - What is happening to this child now?
2. What is the **likelihood** of the child being harmed in the future if nothing changes? Hold in mind the **strengths and protective factors** for the child and family.
3. What is the **impact** on this child's safety and development, of the harm that has occurred, or is likely to occur?
4. Can the parents hold the child in mind and prioritise the child's safety and developmental needs over their own wants and constraints?
5. From the point of view of each child and family member, what needs to change to enable safety, stability and healthy development of the children?
6. If the circumstances were improved within the family, what would you notice was different – what would there be more of? What would there be less of? Who would notice?

Once information has been gathered, the next step is to integrate the collected information, synthesising current strengths and difficulties in the child's situation – the pattern and severity of harm, the current risks, and the strengths and protective factors. Keep in mind that risk can fluctuate and quickly become serious. The analysis and planning stage is ongoing and dynamic. It needs to be flexible and adaptable as new information comes to light. Good practitioners can observe and gather information in a way that does not make the family feel judged. The more practitioners can help families relax enough to talk, the more they will find out about the risks and their capacity for change, and the better the assessment will be. Any assessment is limited to the knowledge available then and the quality of the analysis. This section aims to help you to be rigorous in the way that you synthesise information and not to be biased or naive in your professional judgement. The Best interests case practice model stresses the importance of collaborative practice – of sharing analysis and critically reflecting on the *meaning* of the information at hand. Case conferences are a vital means of jointly understanding how risks need to be weighted, what decisions need to be made and the priority actions that need to be undertaken (Miller 2010).

Your ability to build trust is a key component of successful work with families, and you may need to 'hang in there' with some families, remain curious and keep exploring to get to the bottom of the issues. Remember the following:

- Initiate family meetings with extended family members as appropriate. At family meetings it should be carefully assessed whether the child should be present. If it is assessed that the child should not be present, the Practice Tools for Working with Children at the end of this publication can be used to present the child's views to the meeting.
- Initiate professionals' case conferences. If the child has been physically injured, child protection practitioners must attend the Suspected Child Abuse and Neglect (SCAN) meeting at the Royal Children's Hospital, or equivalent other hospital, and initiate discharge meetings (see box below).
- Acknowledge what you don't know and keep engaging the family and other professionals to help you understand so that you get to the bottom of the story, not losing sight of the child as you do this.

- Persevere and be rigorous in your assessment with the most troubled families. The children most in danger will not be helped by superficial assessment.
- Get good supervision that helps you critically reflect on your work and challenge your assumptions and blind spots.
- Try to connect what you are seeing in the here and now with what you know of the family's history.
- Seek information from multiple sources.
- Spend time with the child – alone, together with his/her parents and siblings, at school, in the placement.
- *Observe* the child's behaviour and how it changes in different contexts. Reflect on this and seek advice about whether the behaviours are within the normal range for the age and developmental stage of the child. For example, is it reasonable that a child would have so many accidents? Or sit still for so long in silence? Or freeze and stop playing when he/she sees a particular adult or hears yelling? Or be so physically close to you when he/she just met you? Or remain oblivious when his/her parents argue aggressively? (Miller 2010)

Use this information to assess what needs to be done to promote the child's safety, stability and development, and develop an action plan using the steps outlined in the Best interests case practice model Summary Guide.

The following points are useful at the analysis and planning stage:

- **Use critical reflection.** Synthesise the information you have gathered and make connections with what you are seeing in present behaviour and what you have discovered about the child's family history and repeating patterns. Do not dismiss inconsistencies and contradictions, and become blinded to information that does not fit with your initial impressions or beliefs about the adults involved. Be aware that denial and minimisation is common from offenders and that they are often masterful at deception. Their explanations may have seduced others around them into false beliefs and the child's reality can be lost in that process. Professionals can become stuck in a particular view and captured by the disguised compliance of some parents and become overly optimistic about their capacity for change. A key question to ask yourself is whether the parents' actions and behaviours are consistent with their claims and what you observe in the child's responses?
- **Use a trauma and attachment framework** to undertake a 'critical analysis' of the information. This process needs to incorporate the knowledge and processes we use to consider the impact of cumulative harm. Focus on what has happened to the child and how the child has adapted or compensated to manage his/her pain and survive rather than just diagnosing or describing what is wrong with the child.
- **Develop multiple hypotheses** regarding what in the children's life experience has led to their current presentation. Test them with others using all that you know. Fill the gaps in information as soon as you notice them. Be prepared to be wrong. Your initial hypotheses may well change as you get to know the child and his/her family, and growing trust brings new information to light.
- **Inform children and young people as soon as possible**, preferably the same day, of legal and administrative decisions which affect them (Winkworth and McArthur 2006, p. 20).
- **Consider who has the most positive connections with the child**, and his/her connection to culture, community and school.

- **Plan for the child's chronological age and developmental age**, if they don't match. For example, you may be working with a five-year-old boy who is operating emotionally at the level of a three-year-old. A girl aged 10 may be triggered when she sees her perpetrator and regress to an infantile state.
- **Plan for trauma recovery** in a therapeutic environment if the child is in out-of-home care.
- **Plan for the child's entry into and return from out-of-home care if this is required.** For the child who cannot be returned, is stability assured? What restorative work needs to be accomplished in the child's absence to enable the child to return, or to enable parents to accept a permanent care plan?
- **Plan for contact with family at a level that the child can manage safely** if the child is in out-of-home care and document observations of the child's emotional state before and after access.

Children in contact with the care and protection system should be provided with direct and indirect opportunities to express their feelings and wishes; in this they can be greatly assisted by an adult (other than their carer) whom they trust, who provides regular emotional and practical support and who is likely to have continuous involvement with them (Winkworth and McArthur 2006, p. 20). Empathise with what the child is feeling and experiencing, and what he/she needs and would like to happen next. Be inclusive and seek the opinion of any siblings.

Weight your analysis and planning for the child's best interests, prioritising safety, and development. What is the most important goal now? Critique your plan through the lens of commonsense.

- To clarify the plan, ask who will do what, with whom and by when. Engage families, including extended family members, in solution-focused thinking in regular family meetings (Miller 2009).
- Remain strength-based and forensically astute. Keep it real – don't be overly optimistic or set people up to fail by overloading them with expectations. Equally, you need to balance this with the difficult conversations about what needs to change. Make sure that what does need to change is fully understood by the parents and carers. Avoid court orders with too many conditions and too many referrals. Ask yourself what is the most effective and practical way to help the child and family.

Ask yourself often: How is what I am doing now going to improve the quality of relationship between the parent and child and enhance their capacity to parent to the best of their ability? (Moore & Layton 2010, section 3, p. 3).

For more information on assessing parental capacity where substance abuse, family violence or mental illness is present, refer to the Families with multiple and complex needs specialist practice resource.

Specialist practice resources do not replace the need for supervision, professional development or consultation with specialists. Accessing supervision and giving attention to self-care is important when working with children.

Suspected Child Abuse and Neglect (SCAN) meetings

A SCAN meeting is a multidisciplinary case conference held at the Royal Children's Hospital or equivalent other hospital when a child has been admitted due to suspected abuse or neglect. The SCAN team is comprised of senior Department of Human Services staff, police, The Victorian Forensic Paediatric Medical Service and Royal Children's Hospital or other equivalent hospital medical and social work staff. The meeting occurs within 24 hours of the report of suspected child abuse by the Royal Children's Hospital to the Department of Human Services and police (or on the next possible business day). The meeting is designed to share information and to begin the planning process.

Discharge planning meetings

When a child or young person's injury/condition/illness is undetermined, suspicious, vague or inconclusive, following the completion of all medical assessments (including the forensic medical examination, if required), a case conference may be held before discharge from the Royal Children's Hospital.

Either hospital staff or child protection may convene the conference, but child protection must ensure all relevant social work, medical staff and other professionals (including the police as appropriate) involved with the child/family are invited to attend. In addition to the allocated child protection worker, a senior child protection worker or above, should attend the case conference, endorse and oversee the discharge plan for the child.

Identity, resilience and strengths

Good practitioners talk about whole children and their abilities and capacities, rather than defining them by what has happened to them. Reframe the children's experiences in such a way that acknowledges the ways they have responded to difficult situations. Many children have engaged in positive strategies that have helped them survive years of neglect, poverty or hardship.

The most healing thing for children who have experienced child abuse is the belief and support of non-offending family members and other significant people in the child's life. Part of strengths-based practice is to discover what may be preventing this from occurring. A strengths-based approach sidesteps engaging in a blame game, and focuses on understanding the constraints for the parent and the child and finding a way that the professional relationship may be helpful (Miller & Dwyer 1997). In cases of neglect, there needs to be clear bottom lines about what needs to change, and clarity about who will do what to make the changes within agreed timeframes.

Research findings (Rutter 2006) suggest that protective personal qualities include:

- good intelligence and high scholastic achievement
- secure attachments to caregivers, other family members and individuals outside the family who have a loving, continuous relationship with the child
- multiple harmonious relationships
- a sense of self-efficacy (a feeling of confidence in one's own abilities to deal with things)
- a range of social problem-solving skills
- a positive social interaction style
- a flexible, adaptive approach to new situations.

Practitioners can consider which of these qualities are modifiable, and plan interventions and strategies that improve these qualities.

Practitioners should promote opportunities to:

- cope successfully with challenges and stresses within the child's capacity at any particular point in development (for example, singing in a choir, swimming lessons)
- succeed in a range of circumstances and settings (for example, families, schools, peer groups, communities, sporting and recreation).

The Healing Power of Belief and Support from Family

The most healing thing for children who have experienced abuse is the belief and support of non-offending family members and other significant people in the child's life. Part of strengths-based practice is to discover what may be preventing this from occurring and being solution- focused in helping the family to heal.

Action

A stable environment with family or placement with carers, as well as connection to extended family, school and out-of-school activities are vital to the child's sense of normality and developing competence. Expect that the child will recover and do well, despite setbacks. The child needs to receive the support that he/she needs to feel safe and develop well.

Family involvement

Family involvement in treatment of the child is critical. Abused children learn how to adapt to maltreatment, and what appears to be 'abnormal' behaviour when seen in the family context can be seen as normal adjustment to abnormal circumstances (Doyle 2006). The recovery process for children in the statutory system is highly dependent on the strengths and commitment of family. As such, practitioners' ability to form strong partnerships and engage with family is critical to good practice, even when the child is unable to return home (Miller 2009). Physical separation rarely equates with emotional separation, and a child's identity needs are real no matter how complex the family situation (Miller 2009).

Relationships are central to good practice – relationships that engage people in change, build on strengths and creatively look for solutions in partnership with families, and that are characterised by respectful communication and wise use of authority (Miller 2009). The relationship between engagement and authority, or change and coercion, is not simple. To address this and other issues, establish a process with the client that allows you to:

- Acknowledge the position of clients – collaborate with the people, not the abuse. Canvass how they see the issues and the solutions they have for change.
- Be clear about your professional assessment, that is, your concerns and what needs to happen to resolve these. Feedback has indicated that clients did not necessarily understand what the problem was, and how they were supposed to change it.
- Establish and maintain the bottom line on what needs to change to ensure the child's safety and wellbeing.
- Ensure the client understands the ways in which he/she can request a review process (Miller 2009).

No bull therapy

'No-bull therapy' with families and individuals who are not comfortable with child protection, family services or therapeutic services, has five basic clinical guidelines:

- striving for mutual honesty and directness in working relationships
- overtly negotiating levels of honesty and directness
- marrying honesty and directness with warmth and care
- being upfront about constraints
- avoiding jargon. (Miller 2009)

Explore with the family if there are people within the extended family or friendship network who can help them engage with and use the services needed to effect change. Many 'hard to reach' families are not confident in or have had bad experiences of approaching or using professional services and it is critical to help them build the social networks that will enable them to use services. Families who resist all formal services indicate they are most likely to be assisted in everyday environments that are normal and non-stigmatising, rather than through formal agency settings (Winkworth, McArthur, Layton, Thomson & Wilson 2010).

It is therefore important for practitioners to consider how they can encourage parents to join local networks of support such as Gymparoo and preschool playgroups and choose local interview venues with which the parent feels comfortable such as the local park, McDonald's or the local coffee shop, being mindful of privacy requirements.

A welcoming and supportive stance towards family members and other significant adults is important. If a child is unable to remain with his/her family, attention needs to be given to enhancing stability and connectedness in the broadest sense (including parents, siblings, extended family, significant others, peers, schools, community, culture).

Family work may be not be indicated in families where there is:

- Complete rejection of the child
- A parental failure to take responsibility or acknowledge problems
- Evidence that the needs of the parent take primacy over those of the children
- A combative oppositional stance to professionals
- Severe personality or related problems in the parents (Doyle 2006).

The Best interests principles of the Act clearly state that the widest possible protection and assistance to the parent and child must be given. Goals of intervention need to be developed with the family wherever it is safe to do so.

Broader questions

Key considerations at the action phase include:

- Has the child been given opportunities to form nurturing, supportive relationships with caring adults?
- What indications are there that the child feels safe? Under what conditions does the child's behaviour deteriorate and what additional supports may be required?
- Has the child been given opportunities to consider how his/her behaviours may emotionally or physically affect others? He/she may need to rehearse ways to help stop the angry or really sad feelings. He or she may need help to become aware of, and express feelings in more constructive ways.

- Have opportunities been provided for the child to make, maintain and develop connections to family, significant other adults, pro-social peers, community recreational opportunities and culture? For Aboriginal children, implementing and updating their Cultural Support Plan needs to be a key focus.
- Does the child's current environment help to offset any vulnerabilities he/she is feeling, and support and maintain development?
- Have opportunities been provided for the child to engage in activities to help him/her feel calm, safe and well and to work towards healing any developmental gaps – such as playing ball, kids' yoga, visual imaging relaxation, breathing exercises, art, music, dance, kicking a footy, modelling clay, riding a bike.
- Have health checks been undertaken and any health issues addressed, including dental checks, if a child is moving into a new placement, and regularly thereafter? Ensure that existing appointments are known and factored into any placement arrangements.
- What plans are in place for the child's continuing education, whether mainstream, alternative or distance education? Is further support required?
- What gender and cultural considerations are there, and are they being incorporated effectively?

Working in partnership

Child protection work involves collaboration with families and across sectors and the engagement of a diverse group of professionals, in order to achieve good outcomes for families (Miller 2009). Working effectively in partnership involves all parties having a clear idea of who is the lead agency or worker, having a strong commitment to a common purpose and goals, and engaging in clear communication and processes. In order to offset any possibility of 'systems anxiety' occurring when working with children, clear guidelines need to be set regarding who will manage the system around the child and how a clear, coherent, contained system of care is to be assured. Family meetings, care team meetings and planning is a vital mechanism to ensure this.

Ensure that professionals involved in the child's life continue to receive information from child protection, particularly when, because of competing professional commitments, the professionals have not been able to participate in important meetings about the child's ongoing care (Maternal and Child health Nurses, general practitioners, paediatricians are important professionals to include here). When a child is hospitalised, the hospital social worker is a key liaison person who should be regularly updated on the child protection practitioner's plans and have input into the development of the plans.

It is equally important to refrain from an 'over-search' for people or resources to involve in interventions. More is not always better – too many referrals and services can overwhelm the child and his/her family. A key group of people should form the core working group in planning interventions and engaging with the family.

A successful collaboration involves:

- Family meetings
- Case conferences – especially for high risk families and for children with a range of development needs
- Care teams – for all children
- A pooling of resources for the benefit of the child and family
- Involvement at all levels within an organisation, with each level valuing and supporting collaboration
- Communication regularly, over time and with care involving all partners, in order to be aware of potential problems
- Cooperation with others who can help solve problems for children and their families
- Creativity in generating ideas to help provide new opportunities for kids, using the different skills and experiences of all involved (Moore & Layton 2010).

Reviewing outcomes

As outlined earlier, childhood is an important period of growth, where development occurs in several areas. Regular review of outcomes, therefore, is important to monitor change, particularly in relation to family and other connections and safe or unsafe behaviours. As the practitioner learns more about the family, new ideas or concerns may arise and need to be included in plans. Recovery is rarely linear, but usually messy, circular and multi-layered, and often needs review at particularly difficult times, such as anniversaries (Miller 2009). Reviewing outcomes as plans are implemented can also help refocus efforts on what is best for the child.

Secondary wounding

Secondary wounding that may also be present in the child comes from the minimising, disbelieving, blaming or stigmatising attitudes of others, including family reactions to the young person's situation (Matsakis 1996). This can be just as damaging, and, in some cases, more so than the initial trauma. Secondary trauma can also result from some of the systems, interventions and legal processes. Minimise these wherever possible and support the children and family. Be aware that your actions and system interventions have enormous power to help, but insensitivity can harm. Develop your emotional intelligence and check with families about their experience of how you are working together.

Critical reflection in supervision and in case planning should focus on:

- Do children feel safe and are they developing well? What has changed?
- What safety plans are in place if a crisis arises?
- Have interventions been effective? How do you know? Could anything have been done differently? What could you as a practitioner or your agency have done differently?
- What does the child say is different (outcomes of interventions) and what needs to change in order for him/her to feel safe?
- Do the child and family have a sense of belonging? How do the siblings connect?
- What is the family saying is different, in terms of where they are now and where they want to be? Are parents more able to support their child and meet their child's developmental needs?
- How is the child developing? Have the child's health, sense of identity, thoughts, wellbeing and behaviours improved? Is the child's view of the future positive? Is the impact of past harms being reduced?
- Does the child have friends?
- What is the school saying about the child's presentation, attendance, learning and socialisation?
- Have recreational, leisure and cultural connections been established, maintained, strengthened?

- Has the child's need for stability been met? Have any family contact plans met the child's needs for family connections?
- Is the child being given the opportunity to attend a general practitioner when needed, dentist, other health services, leisure/cultural/religious activities, exercise, good nutrition, peer connections?
- Is there evidence that changes are being sustained over time?

Information gathering and analysis and planning should not be seen as one-off events. Thorough and ongoing assessment is in recognition of the changing nature of childhood, particularly in the developmental domains as outlined in the first section of this document. As such, questions outlined in the Information Gathering section will also be useful at the Review phase.

This resource has given you many ways of engaging and helping children. We have drawn on the evidence from research, theory and practice experience. Be aware that your relationship with child and his/her family is key to making a difference.

Other resources

Children in need of therapeutic treatment: Therapeutic orders facts: Retrieved from http://www.dhs.vic.gov.au/__data/assets/pdf_file/0007/590830/ecec_cntt_factsheet.pdf

- Evertsz, J & Miller, R 2011, *Children with problem sexual behaviours and their families specialist practice resource*, State Government of Victoria, Melbourne. Online: <www.dhs.vic.gov.au>
- Miller, R 2010, *Best interests case practice model: summary guide*, State Government of Victoria, Melbourne. Online: <www.dhs.vic.gov.au>
- Miller, R 2007, *The Best Interests principles: a conceptual overview*, State Government of Victoria, Melbourne. Online: <www.dhs.vic.gov.au>
- Miller, R & Bromfield, L 2010, *Cumulative harm specialist practice resource*, State Government of Victoria, Melbourne. Online: <www.dhs.vic.gov.au>
- Miller, R & Noakes, R 2010, *Child development and trauma specialist practice resource*, State Government of Victoria, Melbourne. Online: <www.dhs.vic.gov.au>
- Robinson, E & Miller, R 2010, *Adolescents and their families specialist practice resource*, State Government of Victoria, Melbourne.
- Department of Human Services, 2007, *Guide to court practice for Child Protection practitioners*, State Government of Victoria, Melbourne. Online: <www.dhs.vic.gov.au>
- Pratt, R & Miller, R 2010, *Adolescents with sexually abusive behaviours and their families specialist practice resource*, State Government of Victoria, Melbourne. Online: <www.dhs.vic.gov.au>
- Dwyer, J & Miller, R 2010, *Working with families where an adult is violent or sexually abusive specialist practice resource*, State Government of Victoria, Melbourne [in press]. Online: <www.dhs.vic.gov.au>

Resources for working with children

Royal Children's Hospital (RCH)

The RCH provides a coordinated medical and allied health service to children and young people. Services provided by RCH where child abuse has occurred or is suspected include:

Victorian Forensic Paediatric Medical Service (VFPMS)

The VFPMS is a medical service providing specialist forensic evaluation and healthcare for abused and vulnerable children. The Royal Children's Hospital governs the service. Clinics operate during business hours (9 am to 5 pm weekdays) at RCH and Monash Medical Centre (MMC) and after-hours services (24/7) are provided at both hospitals. The VFPMS also has statewide responsibilities to provide advice and assistance in relation to the medical evaluation and planning of health interventions when child abuse is suspected. Phone **1300 66 11 42**

RCH Social Work Department

This department provides a comprehensive and responsive service to the entire hospital (inpatient and outpatient). Social workers provide psychosocial assessment, case consultation, liaison with child protection workers and direct services to children and families, including those who are at risk of, or have sustained, physical abuse and neglect.

The Gatehouse Centre at RCH

Gatehouse Centre staff provide specialist counselling services for sexual assault to children/ young people and their families in the north-west region of Melbourne, which forms the Gatehouse Centre catchment area. Counselling is offered to victims of childhood sexual abuse and to their parents or caregivers. Counselling is also provided to children aged 10 to 14 who have sexually reactive behaviours.

Kids Central

http://www.acu.edu.au/about_acu/research/our_research/research_centres_-and-_institutes/institute_of_child_protection_studies/kids_central/

Calmer Classrooms, Office of the Child Safety Commissioner, Victoria

http://www.ocsc.vic.gov.au/downloads/calmer_classrooms.pdf

St Lukes Innovative Resources

<http://www.innovativeresources.org/>

Interrelate Family Centres

<http://www.interrelate.org.au/>

Resources for working with families

Cultural and linguistically diverse families

Brotherhood of St Laurence – Ecumenical Migration Centre

<http://www.bsl.org.au/Ecumenical-Migration-Centre-EMC.aspx>

Forum of Australian Services for Survivors of Torture and Trauma

www.fasst.org.au

Safe Communities for Children

www.mdainc.org.au

Victorian Transcultural Psychiatry Unit

www.vtput.org.au

Aboriginal and Torres Strait Islander families

SNAICC resource service

<http://srs.snaicc.asn.au>

Working with Aboriginal and Torres Strait Islanders and their communities

www.workingwithatsi.info

Victorian Aboriginal Child Care Agency

www.vacca.org

Australian Government programs and services for Indigenous Australians

www.indigenous.gov.au

Guidelines for providing mental health first aid to an Aboriginal or Torres Strait Islander person

www.beyondblue.org.au

Koori drug info

www.kooridruginfo.adf.org.au

National Aboriginal Community Controlled Health Organisation

www.naccho.org.au

Parenting SA Aboriginal parent easy guides

www.parenting.sa.gov.au

Parenting and child health – family and relationships

www.cyh.com

Grandparents

Family law for grandparents

www.lawfoundation.net.au

Grandparents raising grandchildren

www.raisinggrandchildren.com.au

Men and fathers

A booklet to assist new fathers

www.menshealthaustralia.net

Dad's toolkit: building blocks and talking tools for dads

www.families.nsw.gov.au

The fatherhood program

www.fatherhood.net.au

Mensline

www.menslineaus.org.au

Parenting

Centre for Community Health

www.rch.org.au

Dads Appreciating Disabilities Australia

www.dadsaustralia.org.au

Early Childhood Australia

www.earlychildhoodaustralia.org.au

Parent resource cards

www.community.nsw.gov.au

Raising children network

www.raisingchildren.net.au

Experiences in the early months of parenthood

<http://whatwerewethinking.org.au>

Other resources**Disability****Autism Spectrum Australia**

www.autismspectrum.org.au

Children with a disability

<http://raisingchildren.net.au>

Disability Online

www.divine.vic.gov.au

Healthy Start

www.healthystart.net.au

My Time

www.mytime.net.au

Site for primary school aged siblings of children with a disability

www.siblingsaustralia.org.au

Grief loss and bereavement

Australian Child & Adolescent trauma, Loss & Grief Network

www.earlytraumagrieff.anu.edu.au/

The Compassionate Friends

www.thecompassionatefriends.org.au

Grief link

<http://grieflink.org.au>

National Association for Loss and Grief

www.nalagvic.org.au

Mental illness**ARAFEMI (Vic)**

ARAFEMI is a non-profit community-based organisation, with a mission to promote and improve the wellbeing of people affected by mental illness. Details about professional development, resources, library services etc are available on the website.

Beyondblue: The national depression initiative

Beyondblue aims to increase community awareness of depression. The website provides an enormous amount of information on depression, anxiety and bipolar disorder, with resources, research reports, information on projects, symptom checklists and links.

Schools

Calmer classrooms – a guide to working with traumatised children

The role of teachers in the lives of traumatised children cannot be underestimated. This booklet from the Child Safety Commissioner, Victoria encourages teachers and other school personnel to forge vital attachments to traumatised children through two key mechanisms: understanding traumatised children and developing relationshipbased skills to help them. Teachers who understand the effects of trauma on children's education, who are able to develop teaching practices to help them, and who are able to participate actively and collaboratively in the systems designed to support traumatised children will not only improve their educational outcomes but will assist in their healing and recovery.

www.ocsc.vic.gov.au/downloads/calmer_classrooms.pdf

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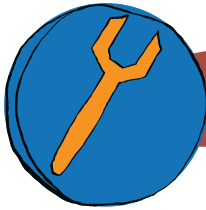
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Practice tools for working with children

'Kids Central' tools and child centred principles

Principle one: Children and young people's safety and wellbeing are of primary importance

KEEP ME SAFE



TOOL 1D: THINGS THAT MAKE ME FEEL SAFE

LINKED TO:

- This tool can be used in all situations where you might engage children directly about their feelings
- Sections 1.4, 1.5, 1.6 & 2.1 & 2.11,



WHY?

- To introduce the topic of safety to children
- To hear from children about the things that help make them feel safe
- To help with safety planning for individual children
- To help families understand what each child needs to feel safe



WHO WITH?

- Children as individuals, in groups or as a family
- 5 – 10 year olds



TIME?

- 15-25 minutes

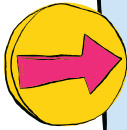


YOU'LL NEED?

- Template
- Coloured pencils / textas

Principle one: Children and young people's safety and wellbeing are of primary importance

KEEP ME SAFE



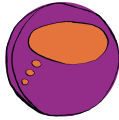
WHAT TO DO:

- Start by explaining the metaphor of the blanket 'I love lying in bed with my blanket. I feel warm and safe and I can hide from the world if I like. On this girl's blanket there are things that make her feel safe: people in her family, her animals, places she can go'.
- Ask children what feeling safe means to them: What does it feel like? When do they feel most safe? What are some of the things that they need to feel safe?
- Get the kids to decide in which of the domains the 'things that make me feel safe' best sit. The domains include: people in my family, other people, animals, places, feelings, things I know, things people can do



SOMETHING DIFFERENT?

- Kids might feel more comfortable cutting images, words or pictures from magazines; using stickers; sculpting answers from plasticine
- If you have time and are working with a creative child why not make your own safety blanket using the domains identified and patchwork pieces representing the things that help this particular child feel safe



TO THINK ABOUT:

- Some kids don't have many spaces or things that make them feel safe: be mindful of this and don't assume anything.
- Help create some spaces for kids where they can feel safe, being mindful that they need to be sustainable (ie its OK that there is a safe space in your refuge but this needs to be recreated at their new flat etc).

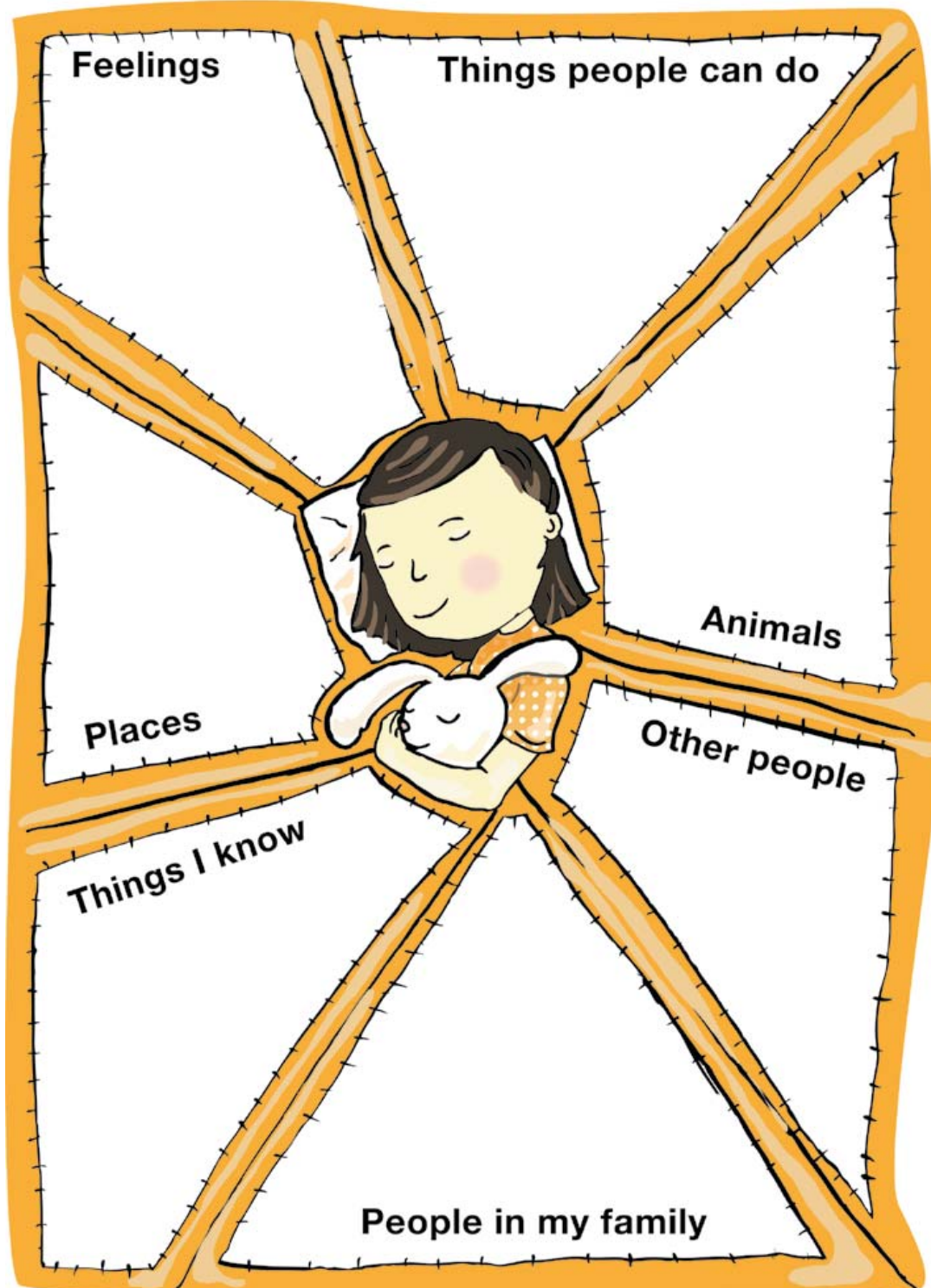


HAZARD ZONES:

- Be aware that kids might want to disclose information about times when they've felt unsafe. It's important that you have made it clear about how you might deal with these messages (see 1.6) and that you've created a space where they know that it's OK to talk if they need to.

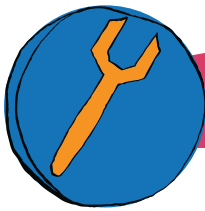
Principle one: Children and young people's safety and wellbeing are of primary importance

Things That Make Me Feel Safe



Principle two: each child is unique & special

I'M ONE OF A KIND



TOOL 2B: 'I'M A STAR'

LINKED TO:

- Sections 2.1, 2.2, 2.3, 2.4, 2.5, 2.10, 2.11 & 4.9



WHY?

- To find out a bit about individual children: their needs and wishes
- Building rapport
- Identifying strengths and wishes



WHO WITH?

- This activity can be completed one-on-one, with a parent and child or in groups depending on the individual child and their situation
- This activity can be completed with children from 4 years and up



TIME?

- You'll need at least 20 minutes to complete this activity

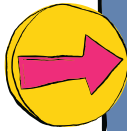


YOU'LL NEED?

- Template (preferably copied onto cardboard)
- Coloured textas, pencils or crayons
- Stickers, stars, coloured wool, sparkles etc for decorating

Principle two: each child is unique & special

I'M ONE OF A KIND



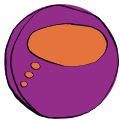
WHAT TO DO:

- Copy enough copies of the template for all potential participants.
- Explain to the child/ren that every kid is different and that it's these little differences that are special and that make them one of a kind. Ask the children to think about and maybe identify some of the things that make people different from each other.
- Explain that you're going to take a look at some of the things that are important to them and things that make them special.
- Hand out the templates and work your way through each of the questions. Children might choose to write words or draw a picture in each box. Let them know that if they don't want to fill in a space, that's OK – you might leave it blank or come up with some ideas together.
- Have a discussion about some of the key questions and answers. While you're doing this, children might want to continue working on their stars or begin decorating them.
- At the end of the discussion, ask children if they'd be happy with you putting the star up in a communal space or getting them to hang it in their room – you might hole punch the top of the star and hang from the ceiling!



SOMETHING DIFFERENT?

- For kids who aren't keen on writing or drawing, grab some magazines, scissors and glue sticks and suggest they find words or pictures that describe the answers for them



.....

TO THINK ABOUT:

- Older children often get fixated with how good their artwork looks (as do some younger children and adults!). Give kids the opportunity to do a draft before beginning.



HAZARD ZONES:

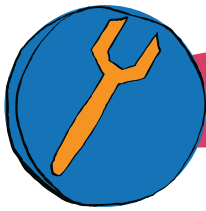
- Some kids might find it difficult to answer the questions about their strengths: without taking over, gently give them some ideas about things that they might include. Alternatively, maybe get other children or their families to come up with some ideas.

Principle two: each child is unique & special



Principle two: each child is unique & special

I'M ONE OF A KIND



TOOL 2C: 'IT'S ALL ABOUT ME'

LINKED TO:

- Sections 2.1, 2.2, 2.3, 2.4, 2.5, 2.10, 2.11 & 4.9



WHY?

- To find out a little bit about how children see themselves, their talents and gifts



WHO WITH?

- Children aged 6 to 12 years either as individuals, in groups or with their families



TIME?

- 15-30 minutes

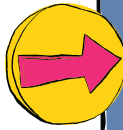


YOU'LL NEED?

- A copy of the template (handout) for each participant
- Coloured pencils and textas

Principle two: each child is unique & special

I'M ONE OF A KIND



WHAT TO DO:

- Tell the kids that all of us have talents and gifts.
- Point out some of the things that you've already noticed about them: the things that you admire about them and the things that you've already seen that they can do.
- Give the children a copy of the handout and tell them that you are interested in knowing a little bit about how they're feeling and what they'd like to have happen.
- Ask the children for permission to ask some questions about what they've drawn and gently get them to explain some of the key questions



SOMETHING DIFFERENT?

- If working with groups of kids or family groups, ask them to identify strengths and 'good things' about other children as suggestions



TO THINK ABOUT:

- There are some wonderful stickers available from organisations like Innovative Resources in Bendigo. These can be used in lieu of pictures when appropriate..

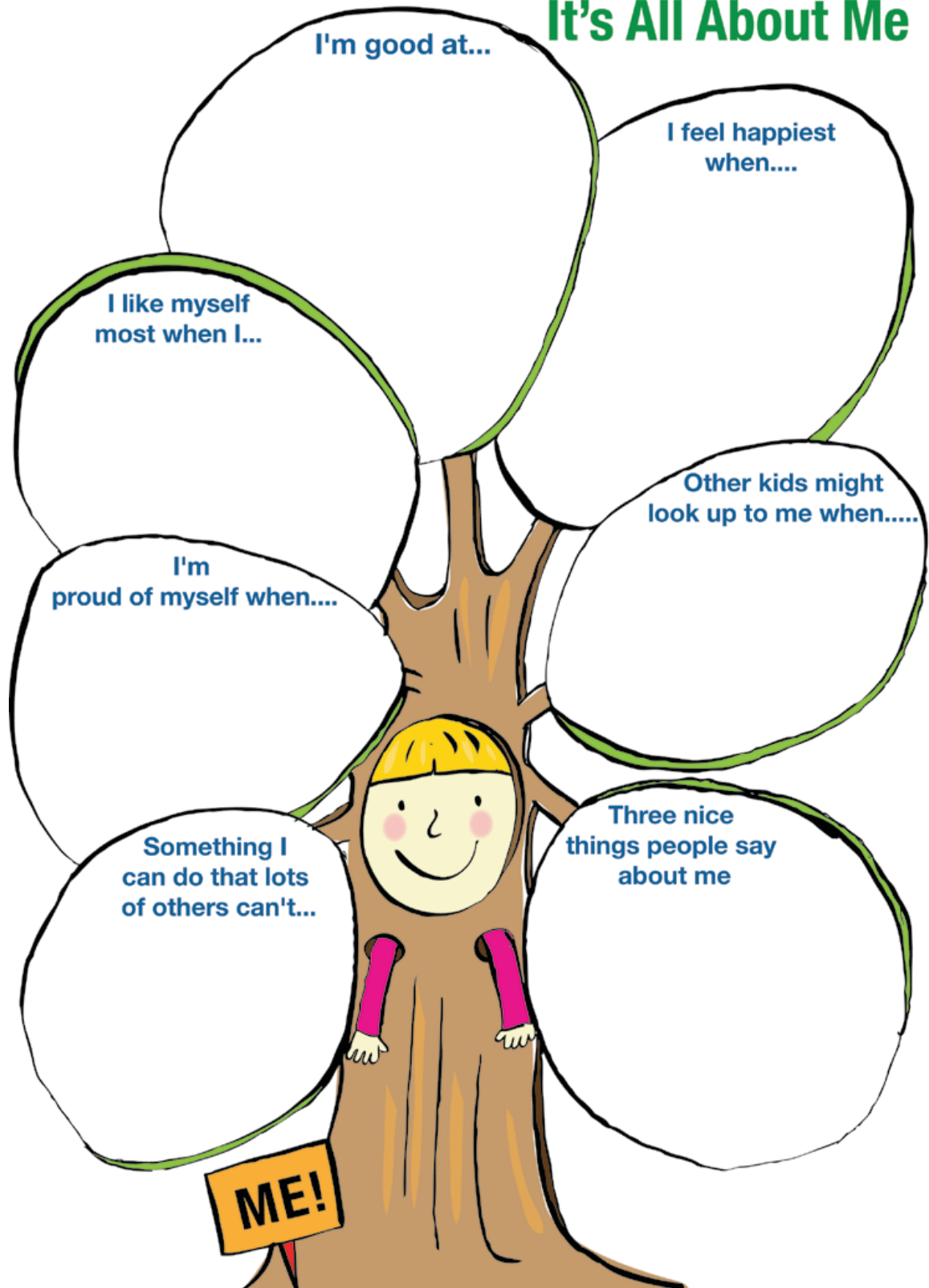


HAZARD ZONES:

- Some kids find it difficult to talk about their strengths – particularly in groups. It's important to set up a safe space and to have some rules about how kids talk to each other. We often do this when talking about sensitive issues – but in an activity like this where kids are feeling vulnerable even when talking about positive stuff its equally as important.

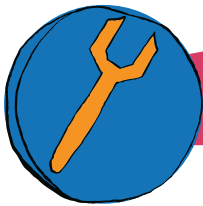
Principle two: each child is unique & special

It's All About Me



Principle two: each child is unique & special

I'M ONE OF A KIND



TOOL 2D: 'WHAT I'D LIKE'

LINKED TO:

- Sections 2.1, 2.2, 2.3, 2.4, 2.5, 2.10, 2.11, 3.5, 5.13



WHY?

- To find out about some of the things that children are thinking and feeling about their current and future situations
- To find out some of the things that they would like to see happen for them and their families



WHO WITH?

- Kids aged 6+ individually or in groups



TIME?

- 10-30 minutes for the first column, longer to fill in the whole box



YOU'LL NEED?

- Copy of the template
- Coloured pencils and textas

Principle two: each child is unique & special

I'M ONE OF A KIND



WHAT TO DO:

- Give the children a copy of the handout and tell them that you are interested in knowing a little bit about how they're feeling and what they'd like to have happen



SOMETHING DIFFERENT?



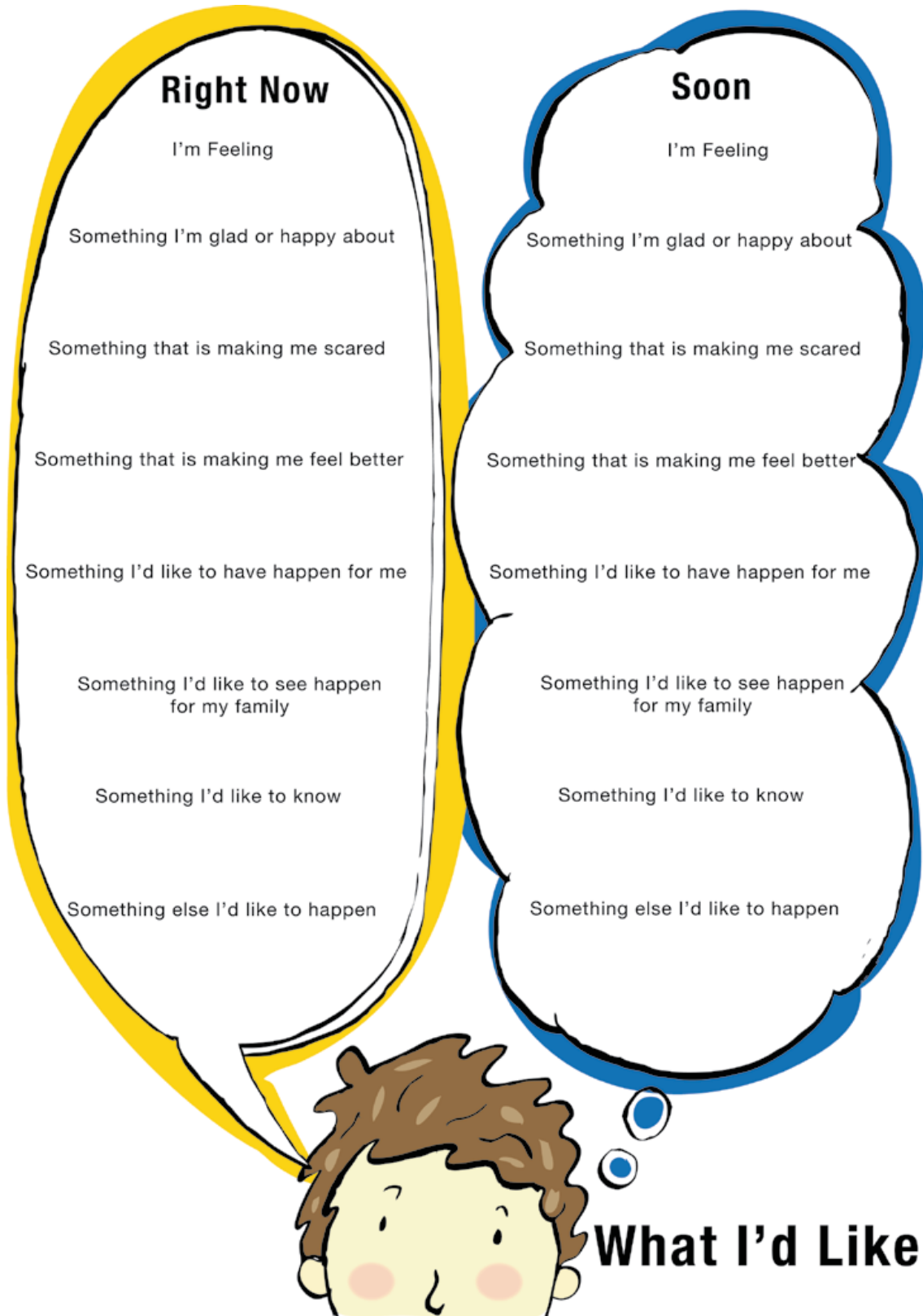
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TO THINK ABOUT:



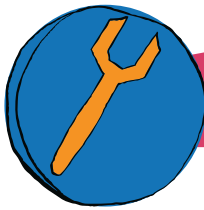
HAZARD ZONES:

Principle two: each child is unique & special



Principle two: each child is unique & special

I'M ONE OF A KIND



TOOL 2E: 'HERE AND THERE'

LINKED TO:

- Sections 2.10, 2.11, 3.6, 5.13 & 6.9



WHY?

- To find out about some of the things that children are wanting and to identify how they might be effected



WHO WITH?

- Children aged 6 to 12 years



TIME?

- 10-30 minutes

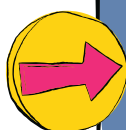


YOU'LL NEED?

- A copy of the template (handout)for each participant
- Coloured pencils and textas

Principle two: each child is unique & special

I'M ONE OF A KIND



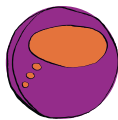
WHAT TO DO:

- Give the children a copy of the handout and tell them that you are interested in knowing a little bit about their hopes and wishes now and into the future
- In the first column, ask the kids to draw a picture of how life is for them right now. They might like to draw / write words that describe:
 - Their family
 - Where they're living
 - Their school
 - Their friends
 - Their other relationships
 - How they feel
- In the third column, have them draw a picture / write words that describe how they would like their lives to be in 1 month, 3 months or 1 year's time using the same prompts as before
- In the middle section, on the bridge, workshop ways that they (and you) might work to get them from where they are to where they'd like to be
- For older children, identifying some of the challenges that they (and you) might encounter can be helpful – do this by drawing some rocks/water under the bridge and discuss how you might deal with these challenges if they were to arise.



SOMETHING DIFFERENT?

- Instead of doing this activity as a writing or drawing task, try it using drama. Get a group of kids to act out what life is like for kids in their situation in the here-and-now and another in there where they'd like to be. Have a discussion about how we might be able to get kids from where they are to where they'd like to be.



TO THINK ABOUT:

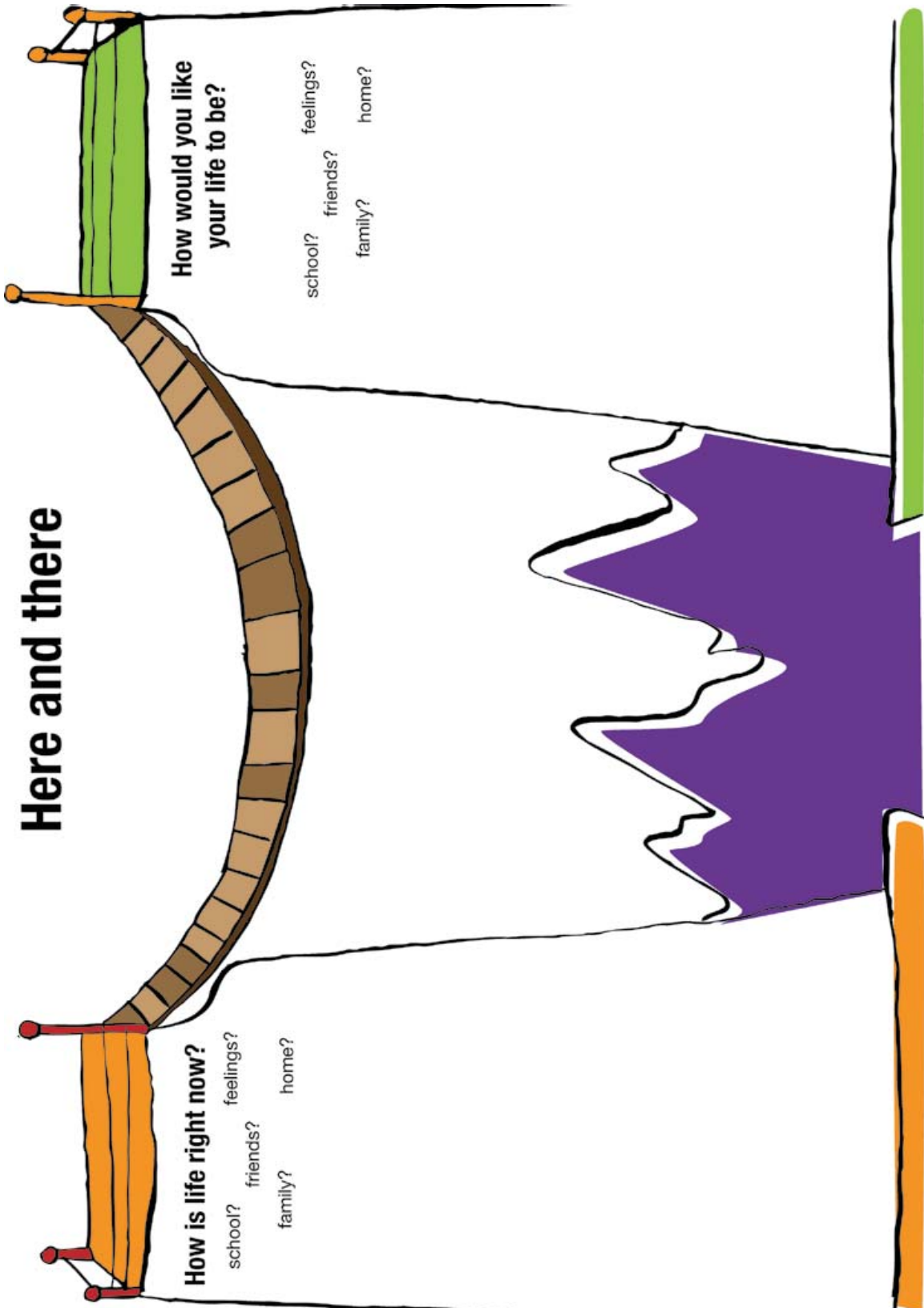
- Children will often believe that their family's circumstance is because of something that they or their family did wrong. This activity should gently challenge this and provide them some hope for the future rather than focus on their family's problems or weaknesses. Take some time considering how things out of their family's control can come into play in situations like these.



HAZARD ZONES:

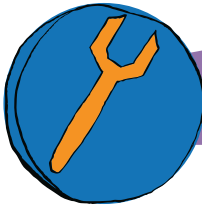
- As with all activities in this resource, workers should adopt a strengths based approach when running this exercise with children. Sometimes there will be difficulties that children will encounter that they don't believe are resolveable – this is OK. Giving children the opportunity to be hopeful is important.

Principle two: each child is unique & special



Principle five: keep me in the loop

KEEP ME IN THE LOOP



TOOL 5C: WHAT I WANT

LINKED TO:

- Sections 2.1, 2.2, 2.3, 2.4, 2.11, 5.9, 5.13 & 6.9



WHY?

- To develop a quick understanding of a child's immediate needs
- Good for inviting children into a conversation about their needs and wishes



WHO WITH?

- Literate children aged 6 to 12 years



TIME?

- 5-30 minutes depending on how involved you and the child get



YOU'LL NEED?

- Copies of the template
- Coloured textas/pens

Principle five: keep me in the loop

KEEP ME in the LOOP



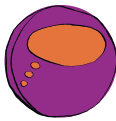
WHAT TO DO:

- Ask the child to fill out the proforma using either words or symbols to answer the questions. Some kids will prefer to complete the form themselves while others may want or need some prompting and gentle encouragement.



SOMETHING DIFFERENT?

- Kids might find it fun to answer the questions as an interview: explain that you're a reporter and are interviewing the world's expert on them. Run through the questions, probing a little as you go.



TO THINK ABOUT:

- This type of activity should be repeated so that you can have an up-to-date idea of how children are travelling. Repeating the exercise and drawing on past versions helps you and the child map growth and change and affirm that you have taken the child's wishes into account.



HAZARD ZONES:

- Kids may want to talk about pressing issues so make sure that you have the time and skills to be able to respond to any problems or concerns that may arise.
- If kids share things that you find difficult to work on, be honest with them and ask if it's OK that you talk to someone else on your team

Principle five: keep me in the loop

What I want

My name is

If I'm worried about something I'd like to...

If I can't talk to my mum or dad I'm most likely to talk to...

If an adult wants to talk to me they should...

I don't want to talk about...

Something that I'd like to talk about is...

A place I like to be is...

Principle six: who else matters?

Who ELSE MATTERS?



TOOL 6A: PEOPLE IN OUR LIVES TOOL 6B: PEOPLE IN MY LIFE

Based on Bronfenbrenner's ecological model as used by Reclaiming Youth International

LINKED TO:

- Sections 1.6, 2.11, 6.1, 6.2, 6.3, 6.4, 6.5, 6.6 & 6.9



WHY?

- To help identify important others in the lives of families and children
- Identifying resources and supports



WHO WITH?

- Children, parents and families



TIME?

- 5-15 minutes



YOU'LL NEED?

- A copy of the template/s

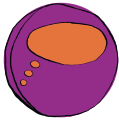
Principle six: who else matters?

Who ELSE MATTERS?



SOMETHING DIFFERENT?

- Have families / kids cut write all the people they get support from on small discs and then stick them into the circles. This allows a bit more creativity and for all family members to participate when in groups



TO THINK ABOUT:

- Rather than just mapping these supports, it's important for services and workers to consider how they enable children and families to capitalise on these important resources. Spend some time considering how these important people in the lives of children and families might be best assisted to support them while involved in your service and beyond (can you provide transport so that kids can stay involved with their sports teams, can your service allow sleep overs or babysitting, can you support parents to talk to teachers about how they might best help the kids at school?)



HAZARD ZONES:

- This activity can highlight children's loss and can bring feelings of grief to the fore. Allowing children to feel these emotions is important as is working with parents to maintain and reconnect children to those who helped them in the past. When relationships are maintainable, working with kids to form new relationships (with new friends, supportive adults etc) is also essential.

Principle six: who else matters?



People in our lives

Who do you receive help from?

What might keep the family from staying connected with these supports?
What might the service do to help them maintain/reconnect with these supports?
How might these supports be used to meet other challenges in the long run? Babysitting? Parenting advice? Respite? Information about support? Fun time?

Principle six: who else matters?

People in my life



Family that lives with me?

Family that doesn't live with me?

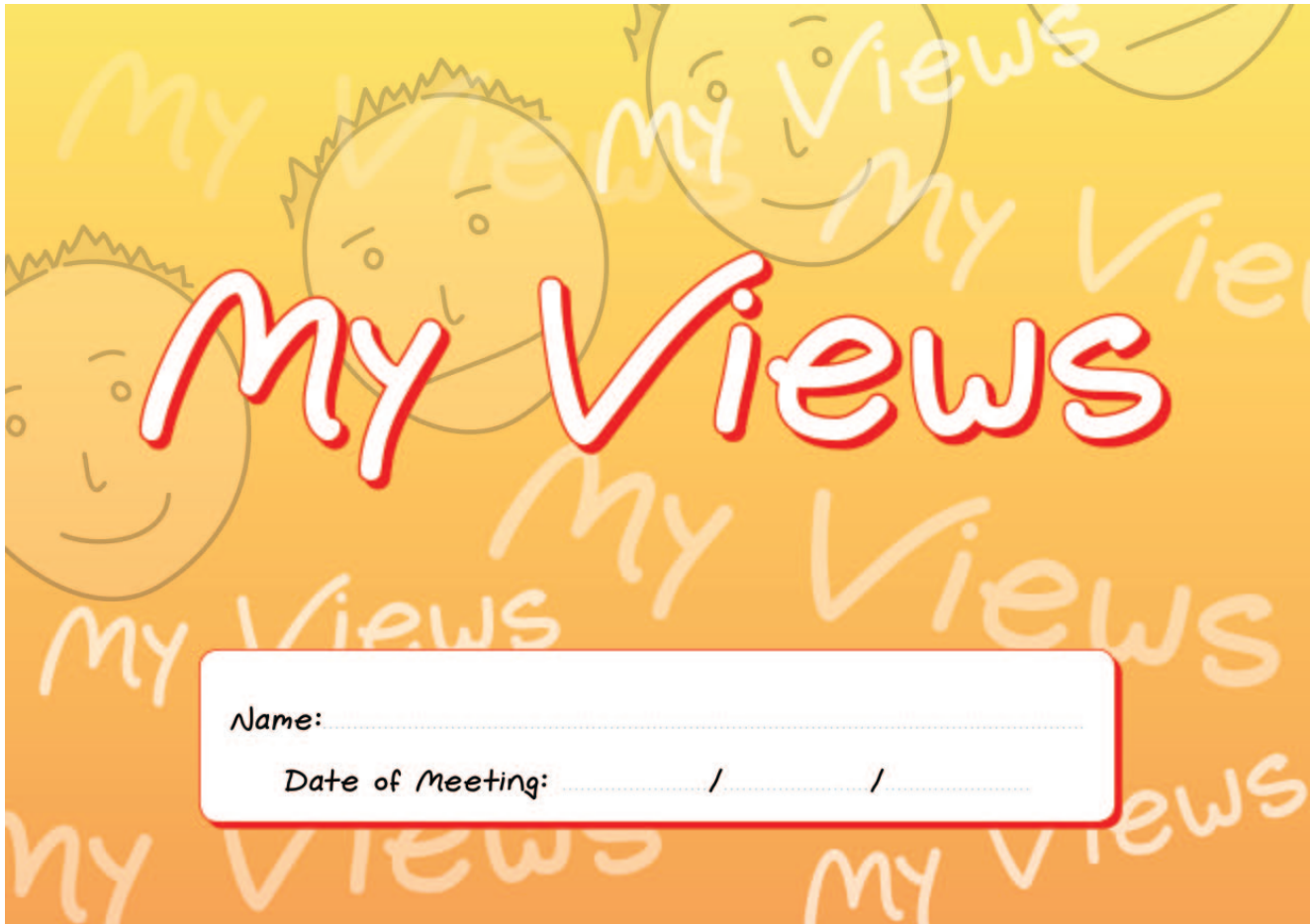
Friends of the family? Teachers? Counsellors?

Friends? Class mates?

Anyone else?

Family Meeting Booklet

My Views - Older children





About my Family Group Conference

What is a Family Group Conference?

- A family group conference is a meeting of members of your family and those working with your family. The job of the family group conference is for you, your family and the workers involved to make decisions about how best you can be looked after and kept safe.



Who goes to the family group conference?

- Your parents and / or the person who looks after you will be there. Other family members and people who are important to you can attend. Those working with you and your family will attend, including your protective worker and possibly your teacher. You may not have met everyone who comes to the meeting.



My Views - Older children (continued)



All about me...

It is important that you have your say and tell the person in charge of the meeting, the convenor, what your views are and what is going well in your life and things you may be worried about.

Let them know by filling in this booklet. There are no right or wrong answers.

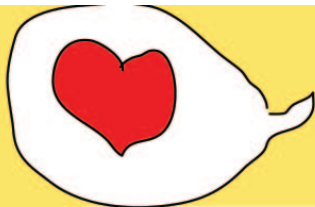
My name is:

I am years old

I live at:

With:

If I was worried about something I would talk to:



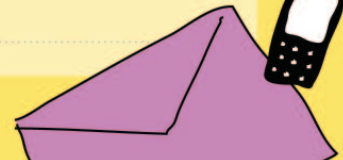
Contact with people important to me...

How do you feel about it? (tick 1)




Who is special to me? This might be your mum, dad, aunts, uncles, friends, neighbours, teachers... ..

What can they do to help make things better? eg. My mum needs to...
My dad needs to... My worker needs to... ..



Where I live...

How do you feel about it? (tick 1)



What's good about where I live?

What worries me?

What I wish was different:



School and work...

How do you feel about it? (tick 1)



How are things at school or work?

What would help me do better?



My Views - Older children (continued)

A healthy you!

How do you feel about it? (tick 1)

T
S U P
K L O M
v v v v v



How healthy do I feel?

Is there anything I or others could do to help me feel fitter?


What do I do in my free time?

Are there any other interests or hobbies I would like to do?











Plans for the future...

How do you feel about it? (tick 1)



What do I want to do in the future? Where do I want to live? Who with? Study etc...

What needs to happen to help me achieve this? Who needs to do what?



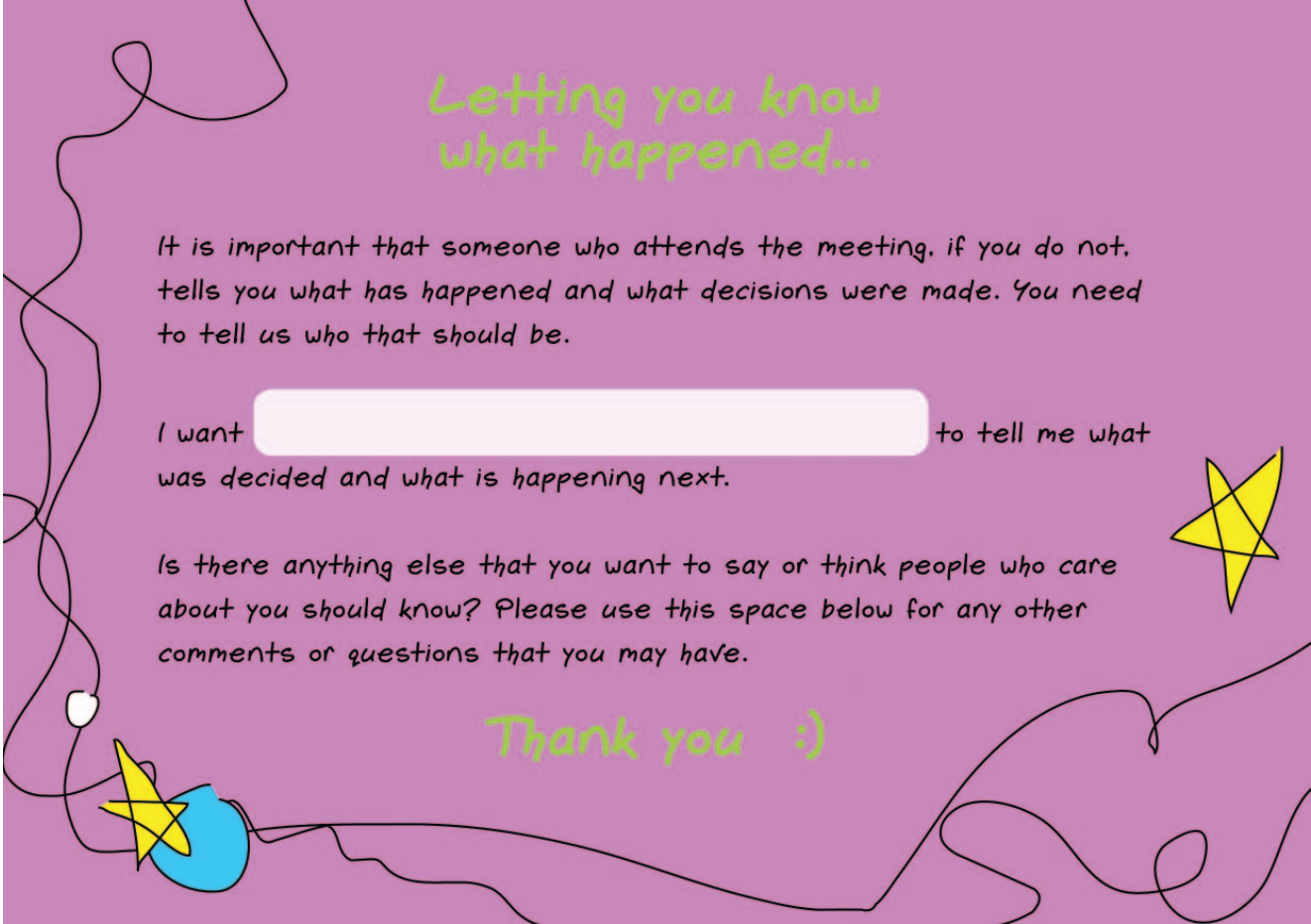
Letting you know what happened...

It is important that someone who attends the meeting, if you do not, tells you what has happened and what decisions were made. You need to tell us who that should be.

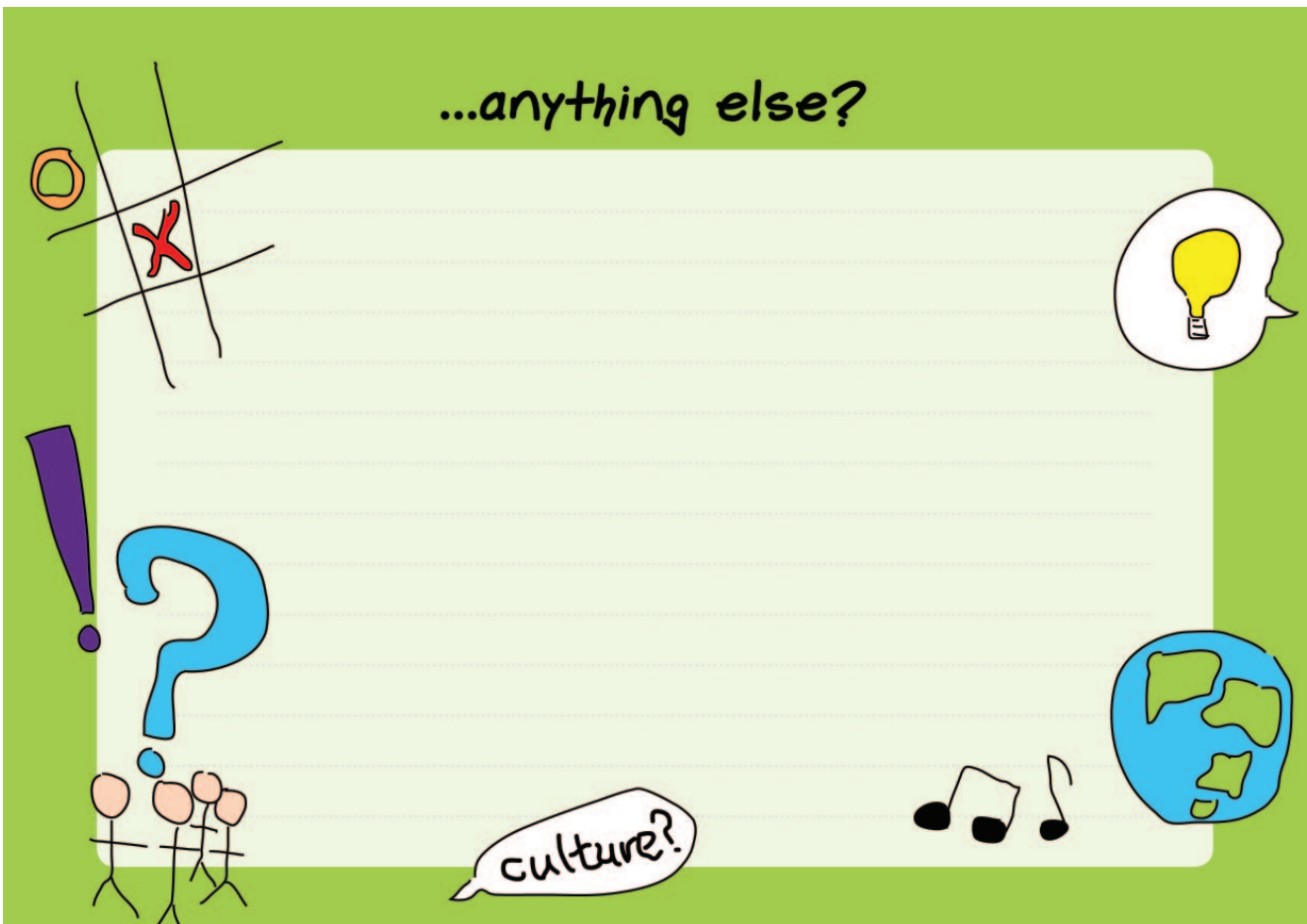
I want to tell me what was decided and what is happening next.

Is there anything else that you want to say or think people who care about you should know? Please use this space below for any other comments or questions that you may have.

Thank you :)



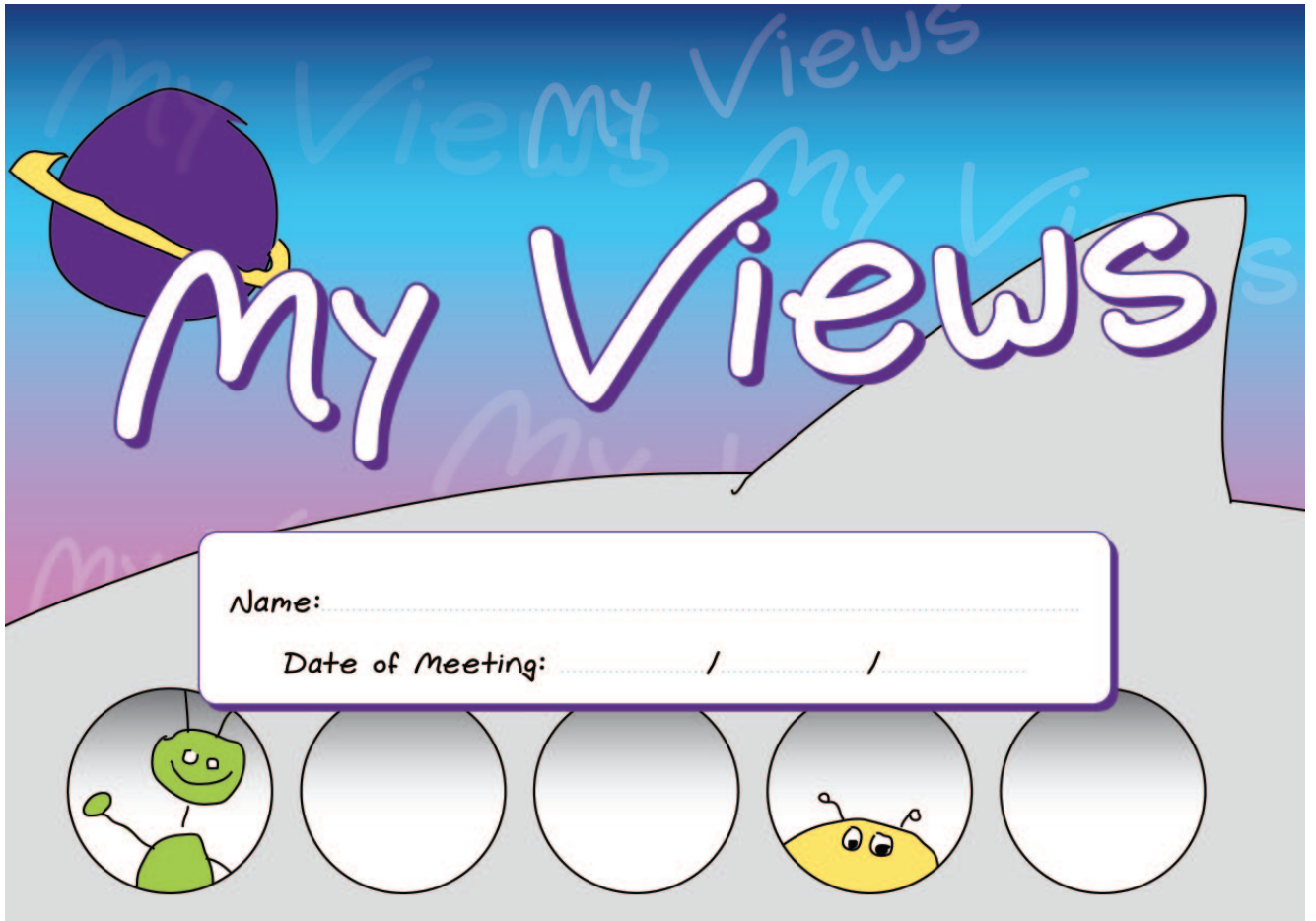
...anything else?



My Views - Older children (continued)



My Views - Younger children



My Views

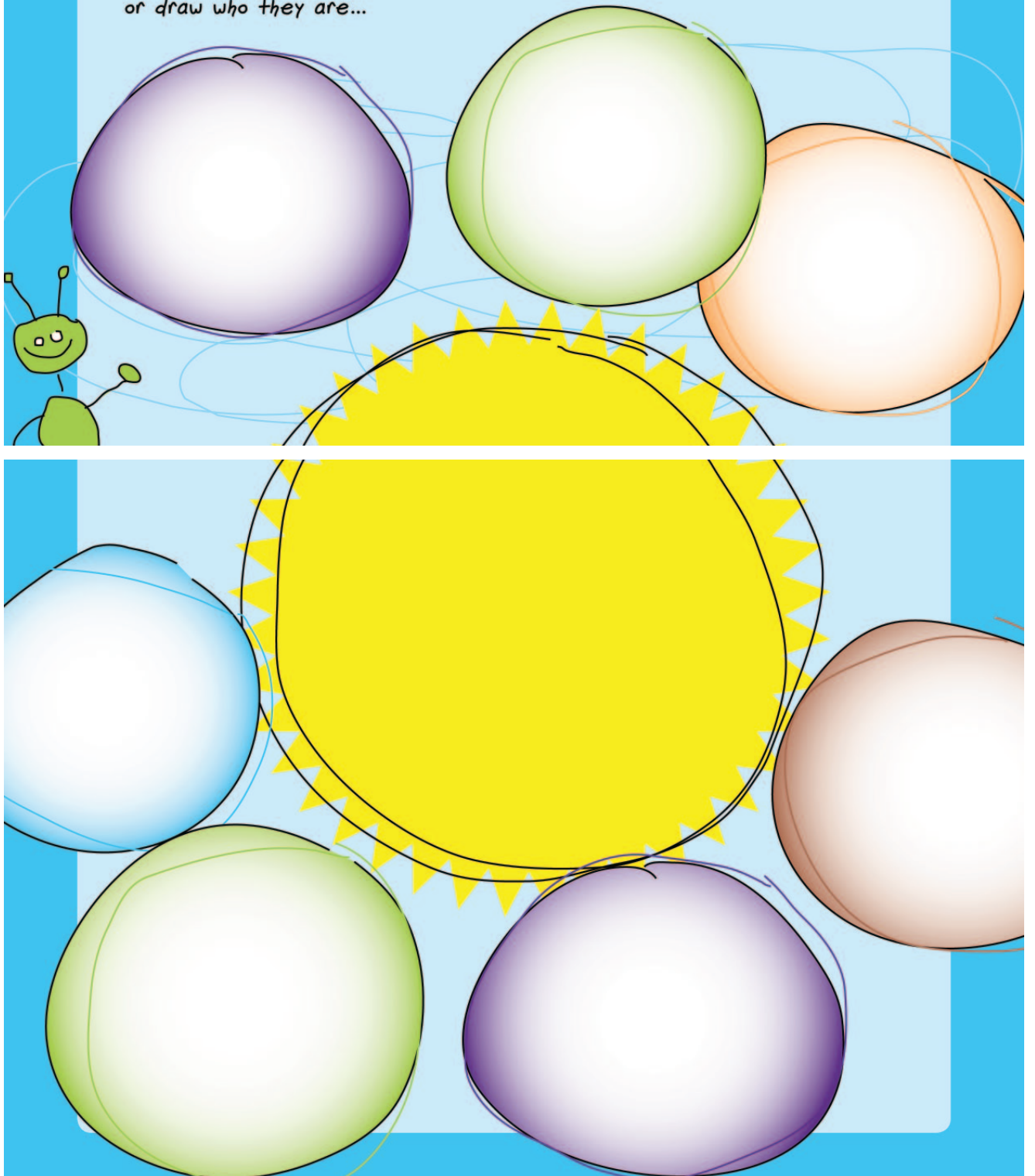
Name:

Date of Meeting: / /

Green alien icon, Empty circle, Empty circle, Yellow alien icon, Empty circle

Who is special to me...

In the sun in the middle draw a picture of yourself and in the other planets draw pictures of the people who are special and important to you. They might be your mum or dad, aunts or uncles, friends or neighbours, teachers or other people who might help you. You can write or draw who they are...



My Views - Younger children (continued)

The people around me...

Sometimes adults don't know what needs to change or how to change it. You can help them by writing down your ideas about what they can do to make things better. You don't have to fill them all in..

I need to...

My mum needs to...

My dad needs to...

Is there anybody else, like friends, grandparents, neighbours or other people who can help make things better? It is OK if you cannot think of anyone else.

My needs to

My teacher needs to...

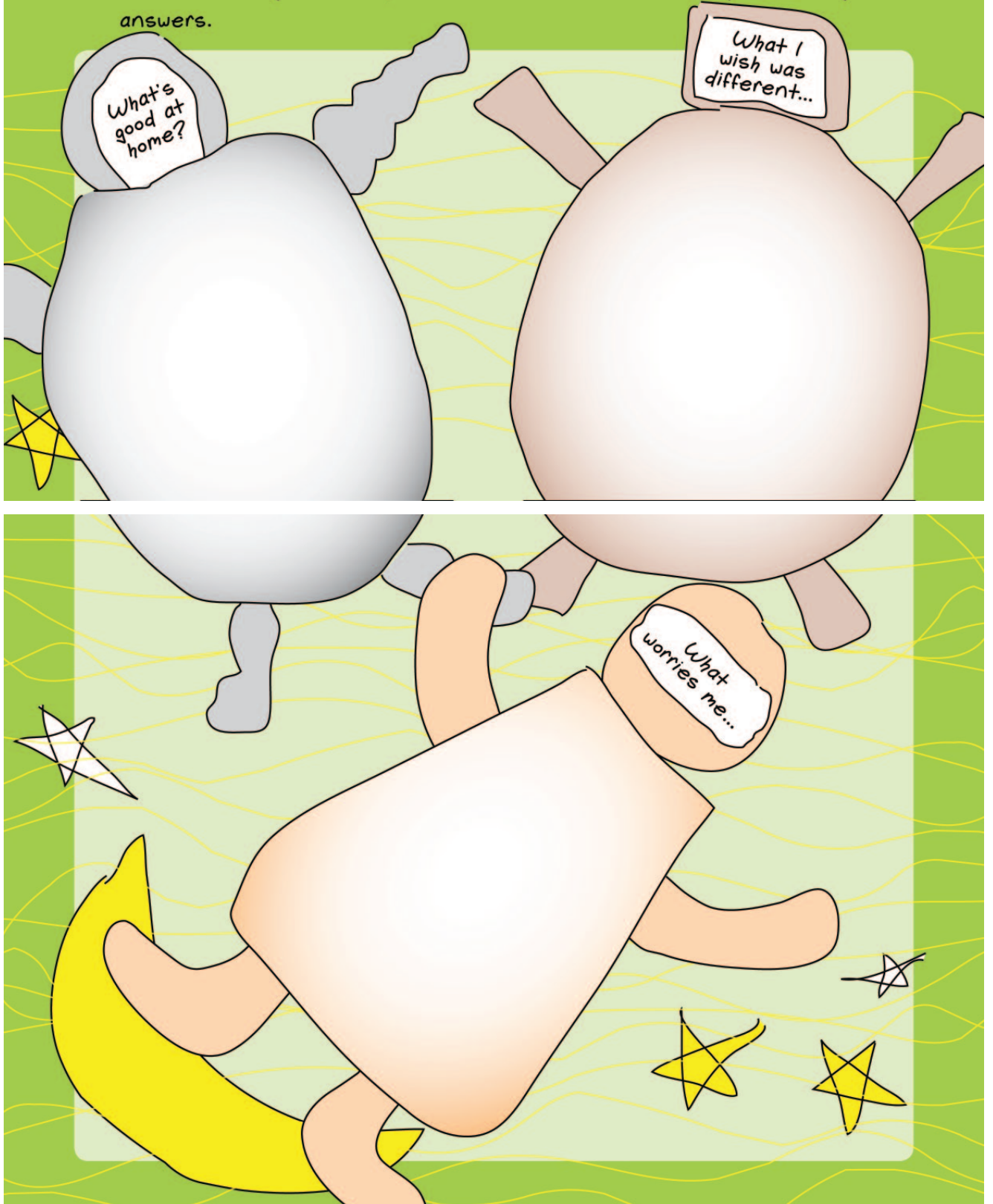
My needs to

My needs to

My thoughts...



Use the spaceman's suits to help the people at the conference know how these things are for you... Remember there are no right or wrong answers.





Child and family snapshot - practitioner field tool

This tool is available online at:

<http://www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families/child-protection/specialist-practice-resources-for-child-protection-workers>

and also as a pad.

Simple Guide to Genograms

A genogram or family tree is a useful tool to gather information about a young person's family. This visual representation of a family can help you to identify patterns or themes within families that may be influencing or driving the young person's current behaviour.

Most young people really enjoy this opportunity to talk about their family history, and it can work as a good tool to build trust and rapport in a working relationship. However be aware that some young people may find seeing a visual picture of the state of their relationships confronting, particularly if the majority of relationships in their life at present are conflictual or distant. Use this tool sensitively and in cases where you think it will be useful to help promote healthy change and the development of more positive relationships in the young person's life. **A copy of this genogram should be recorded on CRIS or CRISSP.**

With the young person

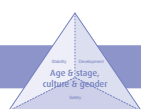
- Aim to gather information about at least three generations: the young person's generation, their parents and their grandparents.
- Include significant others who lived with or cared for the family.
- Start with drawing the family structure, who is in the family, in which generations, how they are connected, birth/marriage, deaths etc.
- You may ask them to tell you a bit about each person.
- As the young person tells you about family members and relationships, make a note alongside the name.
- Ask about relationships between family members
 - Who are you closest to?
 - What is/was your relationship like with...?
 - How often do you see...?
 - Where does...live now?
 - Is there anyone here who you really don't get along with?
 - Is there anyone else who is very close in the family? Or others who really don't get along?
- Ask about characteristics or habits of family members, particularly those relevant to your role: health issues, alcohol/drug use, physical and mental health, violence, crime/trouble with the law, employment, education.
- Ask about family values, beliefs and traditions.
- Try to explore patterns and themes.
 - Who are you most like?
 - What is...like? Who else is like them?
 - Did anyone else leave home early? Is anyone else interested in art, etc?

Symbols for drawing the genogram or family tree

- Female symbol - name, age
 - Male symbol - name, age
 - △ Unknown gender
 - Married - add the year or ages
 - - - - - De facto relationship - commencement date or ages
 - ⊥ Separation - date or ages
 - ≠ Divorce - date or ages
- List children in birth order and put names and ages either within the symbol or underneath.
- ⊠ Death - a small cross in the corner of the symbol (record date if known)
 - ⊙ Dotted circle - this can be used to enclose the members living together currently, for example, who the young person is living with.
 - ~○ Conflictual relationship
 - =○ Very close
 - Distant relationship

Source: <http://www.strongbonds.jss.org.au/workers/families/genograms.html>

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(Insert printer details)
May 2012.



Child and Family Snapshot



Child's name: _____

Child's age: _____

Date: _____

Safety

Stability

Development

These simple tools can be used creatively with parents and children to gather an understanding of their worries and their strengths. The **family snapshot tool** provides an overview of the family issues. The **child snapshot tool** is intended to be recorded separately for each child, so we can reflect on their individual needs.

Distil the essence or the 'headline' issues so that everyone understands what our focus is. Think holistically and synthesise the information you have gathered into simple language that is both clear and family sensitive. Avoid jargon and make sure that it is meaningful for the children and the parents/caregivers.

It is only a point in time 'snapshot' summary, but if you review and complete the tool at different points in time, it will create an opportunity to notice and celebrate success and change, or highlight the need to respond differently. Listen to the family's story and respect their pace, while not losing sight of the concerns about the children. The focus on outcomes for the children and family enables reflection on what needs to happen next and with what degree of urgency. Think critically about how the system has responded previously and what we could do now to be more effective.

The family meeting tool can be used as a prompt to guide discussion. Key themes can be summarised under the headings during family meetings, case conferences and care team meetings.

In supervision or reflective practice sessions, it could be used to clarify the goals and the 'where to from here' tasks, under the headings of safety, stability and development.

A copy of this snapshot should be recorded on CRIS or CRISSP. This page can be accessed by downloading it from www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families/child-protection/specialist-practice-resources-for-child-protection-workers

Consider:

- Physical
- Emotional
- Sexual
- Neglect
- Cumulative

Consider:

- Connection to primary caregiver
- Connection to family
- Connection to school and friends
- Connection to community
- Connection to culture

Consider:

- Health and growth
- Education and learning
- Social, Emotional and Behavioural

Child Snapshot

Child's name: _____

Child's age: _____

Date: _____

Safety	Stability	Development
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Worries & Strengths</p> 		

Family Snapshot

Family name: _____

Date: _____

<p>Concerns What worries us?</p>	<p>Strengths What are the positives? What strengths have the family drawn on in other difficult times?</p>
<p>Constraints What would get in the way of things getting better? What have we tried before that didn't help?</p>	<p>Future picture What would it look like if things were better? What would there be more of/less of?</p>

NEXT STEPS

What needs to happen next?
Who will do what by when?

