Strong Families – Safe Kids

Advice and Referral Service Consultation Paper

Sexual Assault Support Service Inc. (SASS) Submission

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Sexual Assault Support Service

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Introduction

Sexual Assault Support Service (SASS) is a free and confidential service for people of all ages who have been affected by any form of sexual violence, including intimate partner sexual violence. We also provide counselling to children and young people who are displaying problem sexual behaviour (PSB) or sexually abusive behaviour (SAB), along with support and information for their family members and/or carers.

The range of support options available at SASS includes counselling, case management (including safety planning) and advocacy. We also provide information and support to professionals, and deliver training workshops and community education activities in a range of settings including local schools and colleges.

SASS's Crisis Response Service provides 24/7 crisis response and support to survivors of recent sexual assault, and their support persons (including family members, friends, and professionals). SASS coordinates forensic medical examinations and police statements, and can assist with referrals to other agencies. The crisis response service is also available for people who are experiencing trauma responses, including high levels of distress or anxiety, as a result of recent or historical sexual assault incidents.

Approximately one third of all SASS clients are children, and SASS therefore engages with Child Safety Services (CSS) on a daily basis. SASS welcomes the opportunity to respond to the *Strong Families – Safe Kids Consultation Paper* and offer our feedback on the new Advice and Referral Service model.

Key areas for discussion (1)

- **What principles should govern co-location or liaison functions?**

SASS strongly endorses the move towards closer inter-agency liaison and/or co-location.

With regard to principles governing co-location or liaison functions, SASS notes the highly effective Victorian Multidisciplinary Centre (MDC) model. Bringing together staff from Centres Against Sexual Assault (CASAs), police and child protection, each MDC operates as a co-located multi-agency approach to addressing and responding to sexual assault and family violence. The model has been widely lauded as a great success in improving inter-agency relationships, collaboration and knowledge, victim outcomes and wellbeing, and criminal justice responses.

The MDC model was independently evaluated in 2012 and again in 2015. The findings of these evaluations provide useful insights into important principles governing co-location initiatives. We note the following key outcomes identified in the 2015 evaluation of the MDC model, which are of particular relevance for the proposed Advice and Referral model:

- Almost 50% of CASA staff within MDCs report being involved in child protection and police investigations on a weekly basis.[1]
- Significant increases have occurred in referrals from child protection to CASAs since co-location commenced, with two CASAs reporting increases of 107% and 124% respectively.[2]
- MDC Child Protection Teams have on average less than half the re-notifications of non-MDC locations. Non-MDC locations have reported an average of 15-21 re-notifications over the past seven years, compared to a range of 4-10 within MDC locations. MDC staff believe that this because cases are jointly managed by all agencies, which greatly improves responses and outcomes.[3]

Mutual respect between agencies, and a strong commitment to collaboration between co-located agencies was thought to be critical to the success of the initiative. The following excerpt from the 2012 evaluation report highlights this:

> Stakeholders emphasised that the success of co-located service delivery is dependent on the continuing goodwill and commitment of participating agencies. It was said that without continued investment in maintaining good relationships across and within industry sectors, the system was not likely to function well in the long term. Ongoing consultation and debate were perceived by stakeholders to be the key elements for successful collaboration. Although most stakeholders acknowledged that co-located service delivery had increased collaboration between professionals, all recognised that co-location in itself was not synonymous with good collaboration and that continued investment in building and maintaining relationships was required.[4]

The same evaluation found that regular team meetings, informal liaison and case discussions between staff from different agencies were felt by participating stakeholders to be important in avoiding and/or negotiating conflict.[5] 'Informal socialisation' or exchange (for example

shared coffee breaks) was also thought by some stakeholders to be an important aspect of collaborative co-located work that could not be underestimated, as well as the existence of formal structures to address interpersonal conflicts.

In the 2015 evaluation, strong leadership and governance were also identified as a key feature, and included the following elements:

- Setting out a Memorandum of Understanding that defines roles and responsibilities, standards and governance arrangements for the provision of services;
- Early establishment of shared principles and values;
- Nominating one agency as the governance lead/site coordinator – who also drives shared initiatives (such as joint training);
- Regular governance meetings; and
- Strong leadership. This was found to be a particularly important factor in creating and maintaining quality collaboration, professional boundaries and respect.[6]

We highlight the MDC model in particular because we strongly believe in the value of co-location of collaborating agencies. We are keen to be considered as a key partner in any proposed model of co-location. Approximately one third of all SASS clients are children, all of whom will have had some form of engagement with CSS ranging from short term interventions to 18-year care and protection orders. It is vital for SASS and CSS to work closely and effectively together. Challenges currently arise in communication and collaboration on shared cases. Co-location would address these challenges and promote more efficient and effective collaboration between SASS and CSS, directly benefitting some of the most vulnerable children in Southern Tasmania.

- **What barriers are there to co-locating services and how may they be addressed?**

The MDC experience also provides valuable insights into the challenges of co-location, specifically that:

- Building design and infrastructure are important factors in the co-location initiatives. For example, whilst a number of Victorian MDC locations have purpose-built facilities that encourage and support collaborative work, some do not, and this is thought to affect the degree to which collaborative practice can occur between the agencies involved.[7]
- Co-located services require operational budgets to cover shared resources – from smaller items such as kitchen supplies, to larger items such as joint training and infrastructure.[8]
- Ensuring good governance is key – it is critical to have collaborative participation in strategic planning, building shared values and understandings, workforce development, risk management, and data collection.[9]

Key areas for discussion (3)

- **How can the Community Sector Liaison Function support collaborative referral processes for children and families?**

SASS is concerned that the Community Sector Liaison Function will not be effective in building networks between CSS and the community sector. There is a risk that the Community Sector Liaison position would become a 'messenger' between CSS and external organisations, when direct communication between workers about a common client would be a more effective approach. SASS suggests that resources could be better directed into building strong networks between CSS Team Leaders and other staff, and community sector organisations.

Key areas for discussion (4)

Members of the community, mandatory reporters and families will continue to be able to access advice and support from the community sector in situations where a child is not considered to be at immediate risk of harm, or where there is a broader family issue rather than a specific child issue.

- **How can Community Sector Organisations (CSOs) be supported to continue to work with these families?**

CSOs can be supported to continue working with these families through ongoing engagement by and support from CSS. For example, CSS will sometimes refer a child to SASS where there are concerns that the child has been sexually abused, but where there has been no disclosure from the child. CSS will then proceed to close the case. This can be challenging for SASS as we are not an investigative agency, and this leaves SASS solely holding duty of care and safety monitoring responsibilities for children who may be 'at risk'. SASS is expected to notify CSS if a child fails to attend appointments or if further safety/risk factors are identified. However, in a number of situations, reporting and advocacy from SASS in relation to the need for further CSS safety management interventions appears to have been ignored. SASS perceives that reporting regarding safety concerns in relation to a child who is a 'closed case' is at times not viewed by CSS as a priority.

It is not clear whether, when taking on a referral such as that described above, the CSO is taking on the risk and responsibility for that child. This needs to be clarified. This also raises the importance of CSOs receiving comprehensive referrals that contain all relevant information regarding the child and their history (discussed further below under Discussion Area 7), to ensure that they can respond appropriately.

To overcome this challenge, SASS proposes an approach where referral from CSS does not signal the end of CSS's engagement with the child. Instead, we propose that in the case of shared clients, CSS work collaboratively with the CSO involved on a mutually agreed case management plan and joint safety strategy for the child. We suggest that a designated 'lead' case manager be appointed for each case. Lastly, we propose that cases referred to the CSO by CSS are not closed until both the CSO and CSS have agreed that relevant interventions are completed and there are no ongoing risk or safety management issues. This type of approach

will discourage CSS and CSOs from viewing their work with a child or family in isolation, but instead view it as part of a collaborative approach.

We note that the development of Memorandums of Understanding between CSS and CSOs could be valuable, to outline how the working relationship will function and establish shared policies and procedures.

Key areas for discussion (5)

The Triage and Referral team undertake an initial screen and triage for people contacting the Advice and Referral Service and to direct contact to the most appropriate place. This will require better access to information and good working relationships with a range of services, and a reconsideration of assessment practices to ensure efficiency while maintaining integrity of the process.

- **What additional supports or tools will Triage and Referral require to triage effectively?**
- **What additional staff/skills and expertise are required within Triage and Referral?**
- **What education and training is required to support the role of the Advice and Referral service, particularly with universal and other services who support families?**

SASS suggests that Triage and Referral staff should be allocated appropriate time and resources to meet with other organisations (such as other government agencies and community sector organisations) to establish common understandings, guidelines and processes for collaborative work. Once these inter-sector connections have been established, further opportunities for networking and shared professional development could also be explored. This needs to be part of CSS professional development/KPI frameworks so that staff and management view it as a valuable and integral part of their work.

Key areas for discussion (6)

The Triage and Referral team undertake an initial screen and triage for people contacting the advice and referral service within a timelier manner than is currently possible. This will require a reconsideration of assessment practices to ensure efficiency while maintaining integrity of the process.

- **What are the key considerations associated with implementing a 48 hour timeframe? Is this timeframe realistic?**
- **What assessment tools are needed to support a more timely initial assessment?**
- **How can the cumulative harm best be assessed as part of the decision making at this point?**

Whilst SASS appreciates efforts to speed up the assessment process, consideration needs to be given to whether information is needed from other agencies/organisations as part of the initial assessment. If so, the 48 hour timeframe may not be realistic. At our organisation, for example, most intake/counselling practitioners work part-time, which means that they may not be able to provide information needed for the assessment within the 48 hour period.

SASS suggests that the Advice and Referral Service investigate the model utilised by the Safe Families Coordination Unit for gathering information on a case. The Unit utilises an array of technical platforms to access relevant information about a family and offender and build up a comprehensive picture of a family's situation.

SASS also suggests that a mechanism be established to monitor calls and reports made to the Triage and Referral team, to ensure that where CSS refers a caller on to a CSO (or other service), the CSS remains accountable for ensuring that the call is appropriately followed up and acted upon.

With regard to cumulative harm, we note Tasmanian legislation does not expressly consider the effects of cumulative patterns of harm on a child's safety and development. In contrast, the Victorian *Children, Youth and Families Act 2005* (CYFA) section 162 (2) sets out that 'harm' towards a child "may be constituted by a single act, omission or circumstances, or accumulate through a series of acts, omissions or circumstances." SASS would strongly support the inclusion of a similar provision in the Tasmanian *Children, Young Persons and their Families Act (1997).*

In the absence of such a legislative provision, we suggest that CSS adopt a clear definition of cumulative harm that appreciates that "cumulative harm may be caused by an accumulation of a single recurring adverse circumstance or event (such as unrelenting low-level care); or by multiple circumstances or events (such as persistent verbal abuse and denigration, inconsistent or harsh discipline, and or exposure to family violence)."[10] Therefore, it can be present in any type of protective concern but is unlikely to be the sole factor for reporting and thus overlooked. The daily impact of these experiences on the child "can be profound and exponential, and diminish a child's sense of safety, stability and wellbeing."[11]

We note that in Victoria's experience, the need to identify and respond to cumulative harm has the most impact on cases of "omission" (neglect) that may have previously been considered as low risk when considered episodically. The Victorian Government has developed a specialist practice resource to provide guidance to practitioners on this issue. The resource notes that,

> In line with the CYFA, Victorian practitioners are required to assess each report as bringing new information that needs to be carefully integrated into the history of the child and weighted in a holistic assessment of the cumulative impact on the child, rather than an episodic focus on immediate harm.[12]

Key areas for discussion (7)

The Triage and Referral team are a critical component of the proposed model and will need to have robust relationships and clear referral pathways to support their effective operation.

- **What is required to ensure that referral pathways operate effectively? Consider: referrals to family services, universal services, other Tasmanian Government services, and child safety services.**

- **How does Triage and Referral establish and maintain service knowledge and relationships to refer to (or broker) the most appropriate service for a child and family?**
- **How can CSOs support the establishment and review of referral protocols and practice?**

In SASS's experience, there are some circumstances in which it would be valuable to be able to talk to CSS about a particular case and brainstorm options, but not necessarily be required to make a formal notification. The determining factors might be:

- the concerns identified have a low to medium impact on a child;
- the child is not at immediate risk; and
- a formal notification may have the effect of deterring a family from accessing CSO services, and it is agreed to be in a child's best interest to try a different approach.

For example, SASS recently had to make a notification regarding a child client. The child's situation was deemed to be relatively low risk, with the child living the mother after the parents had separated. After making the notification (which concerned the child's father), SASS informed the child's mother that we had done this (as is standard practice). The mother then completely disengaged from SASS and stopped the child's attendance at counselling sessions. In this type of situation, it would be helpful for CSOs to have the option of consulting with CSS before a notification is activated, to plan an approach that is likely to keep the family engaged, and maintain the safety of the child as the key priority. Such a process would require CSS representatives to have the time to work with CSOs in developing a comprehensive, effective approach. It would also require a standardised understanding and process across CSS of how to engage in this type of collaborative process.

Collaborative work goals could be included within CSS workers' KPIs, if they are not already. SASS believes that referral processes work best when there is good communication and information-sharing between CSS staff and community sector organisations. The following thoughts were expressed on this subject by a SASS practitioner:

> I have found it invaluable to call and talk with CSS workers when making notifications (as opposed to email) as often they provide information back to us that we do not otherwise get, and it helps develop grass roots level working relationships with CSS workers. I think it aids in communication when I know the worker on the other end of the line, and have spoken with them previously.
>
> Things don't work well when there isn't a sharing of information. Some CSS workers are good at being pro-active and contacting us about certain cases, and other times we don't seem to hear much from them.

SASS has experienced challenges in the timeliness of receiving referral information. As an example of this, SASS recently received a referral from a CSS staff member in a rural area. The SASS intake worker then tried to contact the CSS worker to finalise the referral, leaving messages and emails over a period of several weeks but receiving no response. This meant

that SASS could not move forward with the referral. This prolongs the time it takes to enable a child to receive support from SASS, and takes up a substantial amount of SASS staff time. This kind of situation indicates a need within CSS to establish internal processes that require referrals to be followed up within a set, reasonable time period.

The quality and content of referrals is another important factor. Whilst some referrals are comprehensive, others have limited and/or incorrect information. SASS practitioners have noted that CSS could better assist services like ours by providing as much information as possible about a case. Ideally, the referral should include as much detail as possible about instances of abuse, sexual assault and/or problem sexual behaviour, as well as the child's history and any other relevant information. Receiving as much detail and historical information as possible about what a child has experienced assists the practitioner significantly in their work with the child, whereas only having vague or partial information makes the counselling process harder in terms of talking with the child about what has happened to them. Sometimes it appears that the CSS workers themselves might not be aware of the details of the particular case, or they are cautious about giving out detailed information. SASS staff have also experienced situations where CSS has not informed OOHC carers about pertinent information such as the risk of the child displaying problem sexual behaviour, and it has taken an incident and a referral to SASS for them to learn of the risk.

Referrals also need to include the details of any orders concerning the child – as SASS (and presumably other CSOs) list the legal guardian of the child as the first point of contact. Challenges arise where a parent who is not the legal guardian contacts SASS for information, and we do not have clarity as to with whom we can provide information, communicate and organise appointments. CSOs also need to be informed if legal guardianship changes at a later point. Finally, it would be useful to have advice from CSS on how CSOs should engage with parents who are not the legal guardian of their children.

One suggestion to improve the referral process would be for CSS to institute a 'warm handover' with the CSO they are referring to. This could be attended by the CSS worker, the child's carer or parent, and the CSO worker. This would enable all relevant parties to meet each other and start to build a relationship; give the CSO the chance to gather all of the information they require; and provide an opportunity to establish a collaborative case plan. The attendance of the child's parent or regular carer is vital, so that they are equipped with the information that they need to support the intervention process, in the child's home environment.

Key areas for discussion (9)

It will be critical as part of the proposed model to establish clear governance and decision-making protocols to support shared working arrangements between government and non-government services within the Advice and Referral Service, as well as effective referral pathways to key partner services.

- **What considerations are critical for effective referrals? Consider: crisis services (e.g. police, family violence services), family support services.**
- **How do Short Term intervention Teams establish and maintain service knowledge and relationships to broker services, and /or refer to the appropriate service?**

- **What considerations will need to be given to governance of the Short Term Intervention Teams to promote collaborative working arrangements and shared approaches to managing risk?**

SASS suggests that CSS could take the lead in improving communication between CSS, third party care organisations, carers and organisations such as SASS, by having regular care meetings and information-sharing. Community sector organisations such as SASS should also be encouraged to be more proactive in seeking information, maintaining communication and developing grass roots level relationships between CSO and CSS workers.

Working arrangements could also be strengthened between CSS and CSOs by CSS communicating with relevant CSOs prior to making major changes in a child's life, such as changing care placements, as well as asking CSOs for their opinion on the suitability of a child's placement (prior to making changes).

Other points of note

Disability

Although not specifically discussed in this Consultation Paper, SASS strongly believes that it is important to consider the particular needs of children with a disability within the Advice and Referral Service model. Children with a disability are at increased risk of maltreatment and abuse (including sexual abuse), and experience vulnerabilities such as "discrimination, social exclusion, poorer development and lower wellbeing" at a higher rate than other children.[13] CSS has a key role in and responsibility for ensuring that children with disability who are at risk of or have experienced neglect and/or abuse are identified and responded to appropriately. This includes (amongst other things):

- ensuring that disability status is determined at point of referral into the Advice and Referral Service;
- ensuring that staff within the Advice and Referral Service possess the relevant skills, knowledge and attitudes to respond appropriately and effectively to the specific needs of children with disabilities; and
- working with both specialist disability services and universal services to ensure that children with disabilities are being referred to the most appropriate service, and their needs met.

Recognition of SASS as a key partner

We note that SASS is not specifically mentioned under "services who are also working with children and families in need" (page 17 of the Consultation Paper). SASS strongly feels that our service needs to be considered a key partner by CSS, given the high rates of shared clients.

Furthermore, given the extensive benefits of co-location, SASS proposes that a CSS worker be co-located at SASS. It is envisaged that the CSS worker would be responsible for cases involving child sexual assault, and would process referrals from CSS to SASS, and work collaboratively with SASS counsellors, police, and other relevant agencies with regard to shared clients. The benefits of such an arrangement would be significant, in terms of

improving collaborative work practices between CSS, SASS and Police; streamlining and improving the quality of case management; and most significantly, improving service experiences and outcomes for child victims of sexual assault.

[1] Finucane Consulting, Janice Watt Consulting and Kristin Diemer Research Evaluation Consulting. (2015). *Evaluation of Multidisciplinary Centres in Victoria. Final Report.* Prepared for Victoria Police, p. 7.
[2] Ibid.
[3] Ibid, p. 8.
[4] Powell, M. and Wright, R. (2012). 'Professionals' Perceptions of a New Model of Sexual Assault Investigation Adopted by Victoria Police'. *Current Issues in Criminal Justice.* Vol. 23, No. 3, p. 347.
[5] Ibid.
[6] *Evaluation of Multidisciplinary Centres in Victoria. Final Report*.
[7] Ibid, p. 9.
[8] Ibid, p. 37.
[9] Ibid, p. 63.
[10] Bromfield, L. and Miller, R. (2012). *Cumulative harm. Best interests case practice model: Specialist practice resource*. Department of Human Services, Government of Victoria, p. 5.
[11] Ibid.
[12] Ibid.
[13] Llewellyn, G., Wayland, S. and Hindmarsh, G. (2016). *Disability and child sexual abuse in institutional contexts*. Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney; see also Tomison, A. (1996). 'Child maltreatment and disability'. National Child Protection Clearinghouse Issues No. 7 (December 1996); and Commonwealth of Australia. (2009). *Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009–2020*. Accessed at https://www.dss.gov.au/sites/default/files/documents/child_protection_framework.pdf.