BEST PRACTICE MODELS

BEST PRACTICE MODELS for Prevention of Mental Disorders

[2] Selective Programs

- a) Biological factors
- b) Psychological factors
- c) Social factors
  - i Indigenous families
  - ii Immigrant families
  - iii Children involved with bullying
  - iv Child protection and out-of-home care

[2 c iv] Child Protection and Out-of-Home care

Appropriate assessment, reporting of difficulties, case planning for necessary changes, provision of assistance to resolve problems, and monitoring of outcomes is the fundamental basis for child protection. Unless this is done it is not appropriate to make permanent care decisions. The preferred approach is for therapeutic interventions whilst the child is within the family. Voluntary assistance provided by social agencies requires specialist training and supervision, appropriate monitoring of outcomes, and adequate funding to support families in achieving the necessary changes.

Best practice involves a "child centred" model with distinct stages of 'Intake', 'Assessment', and 'Treatment'.

The Intake process begins with the notification call. The response is immediate, with sufficient information-gathering to ascertain whether the next action is to be by police, medical or child protective assessment. If by Child Protection, arrangements for the first assessment appointment are put in place immediately.

The Assessment process involves forming a relationship of communication and trust with the clients, gathering information about the family structure and functioning, past and current history of the problems, and a shared understanding of the issues to be resolved. This should lead to negotiation about how those issues are to be resolved, resulting in the 'Case Plan'. It is an essential part of the healing process for clients to accept that the caseworker is genuinely seeking a good outcome. Ownership of the problem-solving by clients is an essential pre-requisite for success.

If clients are not able to control their animosity and achieve a mutually acceptable commitment to constructive change within a reasonable timeframe this is a prima facie justification for early permanency planning. Recognition of a need but limited capacity to achieve it (such as uncontrolled drug addiction) may justify alternative care arrangements whilst treatment is undertaken, rather than immediate permanency planning.

The Treatment process is the carrying out of the changes that were mutually agreed between clients and Intake worker. This encompasses a wide variety of different agreements, ranging from the 'watch and wait' to the court-based intervention orders. Generally, treatment would be through a family therapy process although sometimes additional components such as individual treatments may be incorporated. The therapeutic contract enables the caseworker to closely monitor the safety of the child as well as the rate of progress.

When children can't live safely at home because of serious child abuse, neglect and family violence, the first preference is that they go to relatives (Kinship Care). Accredited volunteer foster carers also provide care for children and young people in their own homes (Foster Care). Wherever possible, the idea is to reunify children with their birth families eventually, providing this is in the best interests of the child.

For indigenous children treatment and fostering should be in culturally appropriate settings.

Permanency planning should begin as soon as it is determined that family treatment interventions will not be able to resolve family dysfunction within an acceptable timeframe for meeting the developmental needs of the children.

See also the discussion of Child victims of abuse PE3c i.

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