Australian Government

Productivity Commission

Enabling the
public health approach
to protecting children

December 2021

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The Productivity Commission

The Productivity Commission is the Australian Government's independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians. Its role, expressed most simply, is to help governments make better policies, in the long term interest of the Australian community.

The Commission's independence is underpinned by an Act of Parliament. Its processes and outputs are open to public scrutiny and are driven by concern for the wellbeing of the community as a whole.

Further information on the Productivity Commission can be obtained from the Commission's website (www.pc.gov.au).

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Acknowledgments

Abbreviations

ACT	Australian Capital Territory
AIFS	Australian Institute of Family Studies
CAF	Common Assessment Framework
COAG	Council of Australian Governments
GP	General Practitioners
IT	Information Technology
LSCB	Local Safeguarding Children Board
NGO	Non–Governmental Organisation
NSW	New South Wales
OECD	Organisation for Economic Co–operation and Development
PwC	Price Waterhouse Coopers
SCRGSP	Steering Committee for the Review of Government Service Provision
SIB	Social Impact Bonds
UK	United Kingdom
US	United States

Enabling the public health approach to protecting children

About this paper

This paper reports the results of a project that was undertaken to find out what is known about systems that enable the public health approach to protecting children. This approach prioritises universal (primary) support for all families (for example, through maternal child health services) and targets intensive (secondary) prevention on vulnerable or higher risk families, often with a focus on early intervention (for example, parenting programs that build skills and address mental health problems). Tertiary (statutory) child protection services are seen as a last resort when abuse or neglect has occurred and alternative non-statutory approaches (for example, family support services) are not possible.

The project was initially conducted as a scoping review, addressing the question *What is known about systems that enable the public health approach to protecting children?*, using a scoping review method that followed the What Works Review Protocol.[1]

A scoping review is one of two 'What Works' methods — the other being an effectiveness review — that the Productivity Commission (in its role as secretariat to the Steering Committee for the Review of Government Service Provision) has piloted.[2] The aim was to develop a reporting framework that would provide a practical approach to identify from existing research what works to improve service outcomes in areas covered by the Report on Government Services.

The Commission concluded from the two pilot studies, however, that while systematic evidence reviews using the What Works methods are rigorous, they may not always yield practical and useful information for policymakers (PC 2021).

For this review of systems for protecting children, the Commission therefore departed from the What Works method by making its own interpretations of both the literature sourced through the scoping review and the responses to a consultation paper it published in 2019.[3] Evidence sources, drawing on material published before early 2019, included peer-reviewed

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[1] The What Works Review Protocol is available at https://www.pc.gov.au/research/ongoing/report-on-government-services/what-works/what-works-protocol.pdf

[2] Effectiveness reviews assess the quality of published evidence. Scoping reviews are used when there is limited evidence on a topic.

[3] SCRGSP (2019) *What is known about systems that enable the 'public health approach' to protecting children*, Productivity Commission, Canberra.

and grey literature, and supporting material sourced from web searches on national and international reforms. All evidence sources are listed in the *References* (for material cited in this paper) and the *Supporting material* (all other in-scope material).

This paper:

- provides background information about child abuse and neglect in Australia and the focus on a public health approach

- reports key findings from the national and international evidence about factors that enable the movement towards a public health approach to child protection and other factors that impede this change

- draws out implications for policy makers.

Background

Measuring the incidence of child abuse and neglect is difficult, but involvement with tertiary child protection services (for example, care and protection orders and out-of-home care) has been increasing in Australia.[4] Due to changes in IT systems and classifications, long-term trends are not available. But, over the four years to 2019-20, the absolute numbers of children in these services have continued to increase, whilst as a share of the number of children in the general population, the rate is relatively unchanged.

This is despite the fact that, to reduce the need for tertiary services, since 2008 Australian governments have committed to a public health approach to protecting children. This approach, which has been recognised in the National Framework for Protecting Australia's Children 2009–2020 (COAG 2009), focuses on preventing child abuse and neglect from occurring in the first place by addressing underlying risk factors that increase the likelihood that a child will experience abuse or neglect, or where problems do occur, intervening as early as possible to minimise harm (Barlow and Calam 2011; Richmond-Crum et al. 2013).

Key findings from national and international evidence

A shared vision

Several papers suggested that a coherent and well-communicated vision of the outcomes required from a system for protecting children is important for success (for example, Davidson, Bunting and Webb (2012)). This is consistent with the OECD view that developing a vision for a desired future outcome is required when the aim is to bring about

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[4] Tertiary services in respect of child protection relate to services for families where abuse or neglect has already occurred. Primary services target all families and secondary service target those in need. See AIFS 2014 (https://aifs.gov.au/cfca/publications/defining-public-health-model-child-welfare-services-context).

system change (OECD 2017), as Australia is doing by moving to a public health approach through the National Framework.

Integration is central to the National Framework vision: 'from conception to implementation the National Framework had recognised the need for an integrated approach to achieve systemic change' (ACIL Allen Consulting 2015, p. 38). That the National Framework sets out a shared long-term vision to which parties are committed is significant for system integration (Bromfield 2012). Including integration in the vision is consistent with the description in many studies of the importance of collaboration and communication between services that make up child welfare systems and which enable integration to occur (for example Sperlich et al. (2017); and Wiklund (2007)). The extent and form of collaboration between system participants (for example, in identifying children requiring assistance and in providing appropriate complementary services to them and to their families when they are needed) have a large impact on how well the system works.

The National Framework sets out its vision through an agreed headline outcome: for all children and young people to be safe and well. Evidence of a substantial and sustained reduction in child abuse and neglect over time is the agreed target with which to measure this outcome. Six supporting outcomes were also agreed to focus strategies and activity towards the headline outcome and to encourage the shift towards prevention.

Despite this, there is some doubt about whether the public health vision that was agreed in 2009 is unifying Australia's child protection system. There is concern that the system needs to be re-oriented towards prevention and early intervention. More than half of the stakeholders consulted during a 2015 evaluation considered that the tertiary system had benefited most from National Framework focus and activity (ACIL Allen Consulting 2015).

Consistent with this, findings from the material included in this review indicated that the system nationally and internationally is not universally conceptualised as a public health approach and that the focus remains on safety and protection. This could indicate that the public health approach is not clearly understood or, in some parts of the system, accepted.

Differences in norms and values across the system may have contributed to the delayed acceptance of the integrated vision implied by the public health approach. Different professions (for example, health professionals and child protection services) have differing perceptions of their role and approach issues differently (Daro 2009; Davies and Ward 2012; Jack and Gill 2010). A core value of the preventative family support approach — that children's wellbeing can be improved by supporting parents — conflicts with the legalistic approach of the statutory child protection system, which focuses on immediate risk to children, requiring surveillance and investigation. Differences in values discourage collaboration between professions and between sub-systems and are a barrier to developing an integrated system for protecting children (Allen Consulting Group 2008). Concerns about whether other professionals will respond effectively can lead to a reluctance to refer cases to them (Churchill and Fawcett 2016; Davies and Ward 2012; Jordan and Steelman 2015).

Some see inter-professional training and enhanced protocols for information sharing as remedies for clashes of norms and values (Davies and Ward 2012), while others have found leadership to be the most important factor for successful interagency coordination and collaboration (Sun and Buys 2013). A number of papers noted or suggested families and other carers, including those from diverse cultural backgrounds, serve on boards, committees and local decision-making committees (Asawa, Hansen and Flood 2008; Hoare and Wilson 2007).

Commissioning

Turning the vision into reality requires action by governments, as stewards of systems for protecting children. The tasks involved are part of the commissioning process, including:

- translating the vision into more specific objectives
- researching the population to identify the user population and their needs
- designing the legislative and regulatory framework
- allocating decision-making authority
- choosing and designing a service delivery model
- organisational design
- clarifying roles and accountabilities
- developing funding and procurement arrangements
- building capability
- developing a learning process for continuous improvement.

The material included in this review considered these tasks.

Translating the vision in to more specific objectives

The public health vision and desired system-wide outcomes need to be translated into more specific objectives. These objectives operate horizontally across the system (to motivate and guide universal service providers in health, education and emergency services) and vertically (to motivate and guide local providers in government agencies and NGOs). The objectives should have sufficient detail to provide clarity for those delivering services about their specific objectives and their roles in achieving them. Specific objectives enable performance measurement, which is an important element of monitoring and evaluation.

Researching the population and its needs

An effective system for protecting children requires the right data to enable effective monitoring and evaluation (Broadley and Goddard 2015). Data are required about: prevalence of abuse and neglect; risks, protective factors and 'at risk' populations; about

whether interventions worked; and monitoring of change over time. However, the absence of prevalence data is a key impediment to establishing a public health approach. Targeted intervention is held back in Australia by the absence of reliable and comparable data on vulnerable families, and the true rates of child abuse and neglect.

The evidence that is available indicates that some demographic and ethnic groups, and some forms of maltreatment, are over-represented in the data. It is widely recognised that Aboriginal children are over-represented in the child protection system in Australia (Pilkington et al. 2017). Concern that their children will be removed may discourage some families, including Aboriginal and Torres Strait Islander families and young parents, from contacting service providers (AHRC 2017; Titterton 2017). A US study found that some groups are targeted for early drug and alcohol abuse, and observed biases in screening for poor black women (as opposed to wealthy white women) (Anthony, Austin and Cormier 2010). A possible outcome from an emphasis on support services is that more children from lower socio-economic groups will enter the system, and consequently some children will be 'clientised', with the resulting associated stigma (Kojan 2011).

Data sharing promotes understanding of trends, helps to identify need, and is critical for effective collaboration across organisations. Yet each jurisdiction has its own 'language', definitions and data recording practices. This impedes data comparison between states and complicates the evaluation of shared, national interventions. Moreover, definitions change over time, making comparisons of performance over time more difficult both between and within jurisdictions. Mistrust within the system may also impede data sharing. ACIL Allen Consulting (2015) pointed out that a shared and common language on early intervention and prevention would facilitate a shared objective and reform pathway. Other papers mentioned structures or mechanisms to facilitate collaboration and coordination, such as referral protocols and risk assessment tools, to improve information transfer by providing a 'common language' (Adamson and Deverell 2009; Sun and Buys 2013; White, Hall and Peckover 2009).

Designing the legislative and regulatory framework for the vision

Several papers noted that many elements of the system — including legislation, policy and practice — need to be aligned to move towards a public health approach. Privacy legislation and legislative impediments to data sharing and to referral pathways are examples of misalignment. Some authors noted that privacy legislation impedes interagency collaboration or integration of services (for example, Bromfield (2012); Hoare and Wilson (2007)). Roylance (2010) pointed out that legislation impeded data sharing that would enable collaboration. In several examples changes were implemented to address issues of alignment. In NSW, legislative amendments increased the threshold for mandatory reporting (Bromfield, Arney and Higgins 2014). In Tasmania, legislation was changed so that mandatory reports could be provided to community intake services, thereby reducing pressure on the tertiary system (Bromfield 2015).

However, even if legislation is changed to increase consistency with the public health approach, ingrained norms and values can lead to old practices being maintained.

Locating decision-making and leadership for the vision

The location of decision-making and leadership received some attention in the studies and papers included in this review. However, they provided examples of national and local leadership and involvement in decision-making, rather than evidence about the effectiveness of alternative models or guidance about the circumstances and extent to which decision- making should be devolved.

Several papers identified that leadership is required to meet system goals and that poor or fragmented leadership prevents system integration (for example Richmond-Crum et al. (2013). Weak or absent leadership is a commonly cited difficulty in the literature (Sun and Buys 2013). Other papers noted the role of representative leadership and local engagement in achieving system outcomes, or the recognition of this by governments (for example, the Department of Premier and Cabinet Tasmania (2013)). Numerous policy papers indicated that leadership is needed at national, state and local levels (Cameron et al. 2015; Care Inspectorate 2014; Ministry for Vulnerable Children, Oranga Tamariki 2017; State of North Carolina, Office of State Budget and Management and Department of Health and Human Services 2018; Taylor et al. 2014).

Several policy papers provided examples of how to effect leadership for system integration. In Scotland, the role of chief officers includes collective (as well as individual) responsibility for the effectiveness of agencies (Care Inspectorate 2014). In the UK, the Wood review stated that leaders in health, police and in local authorities should be responsible for multi-agency collaboration (Wood 2016).

Other papers noted that governance arrangements must support coordinated service delivery or system integration (for example (Lonne et al. 2015)). Arrangements should include the 'right' incentives for individuals or organisations to contribute toward system goals. One inquiry (in Victoria) found there was too much focus on outputs rather than outcomes for children (Lonne et al. 2015). Similarly, one paper mentioned avoiding a 'case counting' approach (Moran et al. 2007). Two papers provided examples of different governance arrangements that support an integrated system, through governing bodies providing across- system management that help linkages and networks (De Jager 2015) and through governance from just one department where multidisciplinary approaches and service coordination were 'routine' (Gwynne, Blick and Duffy 2009).

National leadership is important for encouraging interagency coordination and collaboration. The Early Intervention Foundation (EIF 2018) noted that the fragmented policy landscape in the UK requires a strong national voice and leadership for children's policy to coordinate the work of the large number of departments. It also supports national oversight to guide, coordinate and enable new activities to fill critical gaps in the evidence base. The UK Government has taken on a leadership role through investing in research and innovation to improve evidence about approaches that work.

In Australia, the second evaluation of the National Framework concluded that its tripartite approach to governance is an innovative and effective strategy for driving collaboration at

national, jurisdictional and local levels. However, its consultations uncovered considerable frustration and uncertainty about the governance and implementation arrangements during the term of the Second Action Plan. The evaluation also found that while the premise of a public health model for protecting children remained relevant with stakeholders, if the Framework is to achieve systemic change in moving towards a more preventive model, then the governance structure needs to include representation from other areas such as health, education and early childhood (ACIL Allen Consulting 2015).

While national leadership is important, examples in the evidence indicate that centralised and hierarchical governance mechanisms are not always optimal. Most on the ground child protection decisions are made locally. There are many examples of decision-making being devolved, where it is considered that local representatives are better informed about local conditions. In the UK, Local Safeguarding Children's Boards (LSCBs) were set up, in part, to introduce local leadership (Davies and Ward 2012).[5] This presumably reflects government support for local partnerships as central to meeting the needs of children, and recognition that a one size fits all approach is inferior to local bodies adopting their own approaches to local problems. Local decision makers need the necessary skills or to have the potential to acquire them.

Developing a shared set of outcomes indicators across government departments and providers could facilitate decentralised decisions that are consistent with system-wide objectives. Several papers commented on representative leadership, particularly at the local level, noting that families and other carers serve on boards and committees. Aboriginal and Torres Strait Islander groups argued that a commitment to self-determination for Aboriginal and Torres Strait Islander people is a core principle that underpins successful partnerships between community-controlled organisations and mainstream service providers (Burton 2012).

Choosing a service delivery model

In jurisdictions included in this review, child protection services are mostly provided through a top-down service delivery model, involving combinations of direct government provision and contracting out, largely through not-for-profit NGOs. The papers and studies did not discuss bottom-up delivery models (or more client-driven service models). Rather, they focused on how to improve the direct government provision and contracting out service delivery models — for example, through organisational and workforce arrangements, role clarification, and funding — rather than comparing them with other possible models that could be used to deliver services within the public health approach.[6]

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[5] Following the Wood review, LSCBs would transition to new local safeguarding arrangements that include collective accountability across local authorities, police and health (HM Government 2015).

[6] Other possible models include Network models (community level model which can involve government in funding and governance, but development and implementation are driven by local organisations) and Centre-based models (integrated service centres that target parents of young children through an accessible universal service platform) (PC 2019).

Material considered in this review included proposals for Indigenous-led solutions to improving outcomes for these communities but did not discuss how these solutions would change the service delivery model. State and territory governments are implementing or considering options that head in this direction, such as increasing involvement of Aboriginal and Torres Strait Islander people in developing initiatives; co-designing processes with Aboriginal and Torres Strait Islander organisations; advancing self-management by Aboriginal and Torres Strait Islander people; employing more Aboriginal and Torres Strait Islander people in services for protecting children; and providing practitioners with training, support and clinical supervision to give them the knowledge, skills and techniques to work effectively with Aboriginal and Torres Strait Islander children and families (Department of Communities, Child Safety and Disability Services 2016; Government of South Australia 2017; Government of Tasmania 2016; Government of Victoria 2018). The Expert Panel advising the New Zealand Government The Modernising Child, Youth and Family Expert Panel (2015) recommended strategic partnering with Kiwi and Māori organisations.

Organisational and workforce arrangements to support the vision

The involvement of services across the three tiers of protecting children is a strength of the public health approach. However, this brings with it an increasing number of agencies and sectors from all levels of government, and the consequent risk that fragmented organisational structures discourage collaborative decision-making and reduce accountability, with no-one taking responsibility. Siloed responses confined to a portfolio or policy area are less likely to be effective because they fail to recognise common causes, the multi-dimensional nature of risks and the complexity of children's needs (Government of New South Wales 2018).

Some studies have identified limitations resulting from insufficient or ineffective communication between organisations and workers. For example, one literature review described the organisational and provider systems for US-based parenting services as 'frequently fragmented with little or no infrastructure to support effective communication between these systems'(Shapiro, Prinz and Sanders 2010, p. 225). In addition, studies described examples of poor communication between different professions; for example, between medical professionals and social workers (Adamson and Deverell 2009; Brandon et al. 2008; Davies and Ward 2012; Fifield and Blake 2011; Hanafin 2013; Jack and Gill 2010; Lewig, Arney and Salveron 2010; Lumsden 2014; Moran et al. 2007; Moxley, Squires and Lindstrom 2012; Sun and Buys 2013; White, Hall and Peckover 2009).

Studies have also identified poor communication as the direct cause and/or effect of other issues. For example, a lack of trust and even 'hostility' between mental health professionals and child protection services could lead to poor communication — a barrier to early identification of problems (Davies and Ward 2012, p. 49). Other identified flow-on effects included misaligned organisational goals or vision, disagreement on key issues relating to interagency collaboration (such as thresholds for intervention or referral), and a failure to pass on valuable information (Brandon et al. 2008; Davies and Ward 2012; Fifield and Blake 2011; Hanafin 2013).

Fifield and Blake argued that communication has 'two strands — information and interaction' (Fifield and Blake 2011, p. 27). Enablers of good communication can be broadly grouped into those that improve the quality of information and those that improve the quality of the interaction. Referral protocols and assessment tools were mentioned as enablers of good quality information, while multidisciplinary teams, case conferences and co-location were identified as enablers of good quality interactions.

Sun and Buys (2013) considered that formal referral protocols between health departments and social workers were, in general, the primary means of communication across these organisations. Standardised communication via referral protocols, in particular assessment tools, were associated with more efficient and effective referral processes. A number of papers have argued that sophisticated assessment tools can help facilitate the public health approach by shifting the focus from narrowly assessed risk factors to conceptualisations of child welfare that take broader consideration of family difficulties (Davies and Ward 2012; De Bortoli, Coles and Dolan 2014; Hanafin 2013; Luckock, Barlow and Brown 2017; Sun and Buys 2013; White, Hall and Peckover 2009).

One such assessment tool — the Common Assessment Framework (CAF) in the UK — included statutory requirements for the establishment of partnerships between children's services (Adamson and Deverell 2009). Several studies considered that the CAF helped in various ways to enable the public health approach to protecting children (Adamson and Deverell 2009; Barlow and Calam 2011; Davies and Ward 2012; Luckock, Barlow and Brown 2017; White, Hall and Peckover 2009). For example, Adamson and Deverell argued that the CAF should 'facilitate a more accurate and detailed picture of a child's needs, leading to more appropriate referrals, earlier intervention and reduced scale of subsequent specialist assessments'. They attributed this to its 'holistic nature' and its requirement for active participation of the child, their carers, and a skilled professional (Adamson and Deverell 2009, p. 401).

On the other hand, the CAF was also found to be a potential barrier to communication of information, with one paper describing its goal of achieving a 'common language' between professionals as 'superficially enticing but ultimately ominous' (White, Hall and Peckover 2009, p. 1214). In particular, the authors argued that the CAF did not appear to succeed in its primary goal of standardising the activity of professionals:

> 'Indeed, in some instances, we observed an inverse effect, with the most able/experienced practitioners omitting to enter information (as described above) whilst the least experienced felt forced by the availability of the boxes on the form to provide some commentary, often using the terminology provided in the boxes themselves, creating a tautological shimmer of the form itself in its completion.' (White, Hall and Peckover 2009, p. 1212)

More generally, Bromfield (2012) listed concerns that the use of risk assessment tools may increase risk averse behaviour by professionals, and Valentine and Katz (2015) described problems arising from subjective interpretations of assessment tools, and how this could lead to different findings around the level of risk.

The papers and studies provided examples of different organisational approaches that would assist the public health approach by reducing fragmentation, but did not identify a clearly best approach, which may vary depending on the circumstances (box 1).

There were few practical recommendations regarding the development of frameworks for collaboration. A number of studies called for more research on collaboration (Appleton 2011; Brandon et al. 2008; Sperlich et al. 2017; Sun and Buys 2013; Wiklund 2007). Wiklund noted that collaboration and associated concepts, such as partnership and joint working, have been used both interchangeably and with different specific meanings. While collaboration enjoyed an almost 'taken-for-granted' status in terms of achieving good outcomes, there was a dearth of evidence as to its effectiveness (Wiklund 2007). Sperlich et al. argued that the development of a 'transdisciplinary conceptual framework' was an 'early step' towards success (Sperlich et al. 2017, p. 4). In addition, Sun and Buys (2013) argued in favour of improved governance of collaborative efforts.

Box 1   Examples of organisational approaches to reducing fragmentation risks

Ways to reduce fragmentation risks without structural change include:

- making agency heads responsible for collective outcomes (Care Inspectorate 2014)

- establishing positions with accountabilities for integrating children's services, including challenging partner agencies (Munro 2011)

- establishing a cross-government taskforce on early intervention to coordinate the work of relevant departments, as is happening in NSW through the Their Futures Matter Implementation Unit (Government of New South Wales 2018)

- multi-disciplinary and cross-agency teams, community hubs and lead professionals (Luckock, Barlow and Brown 2017)

- cross-agency case conferencing (virtual and/or in person) (Sun and Buys 2013)

- interagency planning processes — including agreeing goals and objectives, joint planning of services and sharing data and knowledge — preferably led by central agencies (Allen Consulting Group 2008)

- joint commissioning of services, which is used in the UK (Allen Consulting Group 2008)

- training to help professionals understand their respective roles and responsibilities, the procedures of each agency involved and in developing a shared understanding of assessment and decision-making practices (Munro 2011).

Some jurisdictions have attempted to reduce fragmentation risks by combining agencies, as happened in South Australia, which has consolidated education networks and programs in a new Intensive Support Unit in the Department of Human Services (EIRD 2019).

Clarifying roles and responsibilities for implementing the vision

Clarifying agencies' roles and responsibilities can facilitate movement towards an integrated public health approach by identifying gaps or duplication in service provision; and by

creating and improving accountability arrangements for achieving system goals associated with prevention and early intervention. Collaborative decision-making and service delivery, and consistency in working towards shared outcomes and objectives, are more likely if the various parties understand and agree their respective roles and responsibilities.

> In order that organisations, agencies and practitioners collaborate effectively, it is vital that everyone working with children and families, including those who work with parents/carers, understands the role they should play and the role of other practitioners (HM Government 2015, p. 9).

The contribution of clear roles and responsibilities to accountability was a common theme. Several UK inquiries and reports highlighted that clarity of roles and responsibilities is needed for effective prevention and early intervention. The potential benefits of improved role definition (Daro 2016; Fifield and Blake 2011; Hanafin 2013; Inkilä et al. 2013; Mathews et al. 2017; O'Donnell, Scott and Stanley 2008; Sanders and Kirby 2014; Sun and Buys 2013), and professional training (Adamson and Deverell 2009; Davies and Ward 2012; Hoare and Wilson 2007; Inkilä et al. 2013; Richmond-Crum et al. 2013) were identified as useful.

Before the National Framework was introduced in Australia, universal child and family health and education stakeholders had differing views about their roles in preventing child abuse and neglect. The community sector argued that government agencies involved in statutory protection services needed to relinquish control of these services; and there was a view that services addressing parental risk factors needed to reconceptualise their role in protecting children (Allen Consulting Group 2008). Different views about roles appear slow to change, as the second evaluation of the Framework in 2015 found that an under-developed understanding within the child and family welfare sector of the public health approach remained a barrier to systemic change (ACIL Allen Consulting 2015).

This issue is not unique to Australia. Evidence sourced for this review provided examples of situations where sectors' different views about their respective roles and responsibilities (for example, child protection and health) created a barrier to integrating services.

Integrated or collaborative services sometimes fail due to a lack of clarity regarding roles and responsibilities of practitioners, managers and leaders (Fifield and Blake 2011); Anthony, Austin and Cormier (2010, p. 9) described a 'lack of clarity about which professionals are responsible for completing the screening tool/assessment instrument' as a 'practical barrier' to early assessment. Another study identified uncertainty among nurses about whether they should take an active or reactive approach to reporting concerns (Crisp and Green Lister 2004 cited in Appleton (2011)). In the UK, a failure to share responsibility across agencies was identified in the Victoria Climbie Inquiry Report, cited in Davies and Ward (2012), as one cause of serious system failure. In reviewing the literature, Davies and Ward found that the 'silo' working mentality continued as a common feature of cases that go 'seriously wrong', and noted that differences in funding mechanisms hinder inter-agency working. The same paper also stated that 'sharing of financial responsibility across agencies has proved to be another continuing challenge' (Davies and Ward 2012).

Studies suggested that better role definition could be achieved through referral processes, better distribution of professional responsibility for child welfare, and through interprofessional training. Hanafin (2013) argued that effective referral processes could help articulate the role and responsibilities of each professional involved with the family, allowing each service 'to determine and be explicit about what it brings and cannot bring to the protection of children'.

Some countries use system-wide standards and assessment frameworks as an indirect way of clarifying roles and responsibilities. By providing clear pathways for referring children between primary, secondary and tertiary services, they provide information to practitioners about when they are responsible for addressing an issue and when they should refer it to another service. Hanafin noted that effective prevention and early intervention (in the context of public health nursing in Ireland) is enabled by clear staff standards, and by senior staff effectively managing workforce performance against them (Hanafin 2013). However, the effectiveness of such pathways depends on the availability of services to follow up on referrals and whether agencies are working collaboratively. Practitioners also need to be trained to use the assessment frameworks and about interactions between parts of the system. Moreover, the tasks of obtaining information, interpreting it and acting on it depend on the relationship skills of the people involved (Munro 2010).

Funding to support the vision

In Australia, Commonwealth and state and territory governments provide most funding, often channelled through local governments and NGOs. This raises the question of whether the framework within which funding is provided aligns with the public health approach to protecting children. This could be achieved, for example, through tracking how funding is spent and whether it is achieving the objectives of the public health approach; avoiding duplication between service providers; providing coordination between programs and service providers; and building the capacity of communities to provide services locally (PC 2019).

How funds are divided between primary, secondary and tertiary services affects the capacity to move towards the public health approach. Available data show that the majority of expenditure by child protection agencies is on out-of-home care (tertiary service), and while overall expenditure by these agencies increased over the four years to 2019-20 the proportion spent on out-of-home care has remained the same (just under 60 per cent).[7] It is difficult to determine whether the pattern of spending reflects the combined effects of inertia and entrenched interests or is justified on cost-benefit grounds. Gaps in prevalence data permit competing interpretations of the outcomes of spending. Moreover, justifying expenditure on preventative initiatives can be challenging: the benefits are difficult to measure — because of uncertainty about the counterfactual — and delayed. Nevertheless, there is evidence that they can be considerable, as children benefit over their lifetimes, there are wider social benefits and the demand for public services falls (EIF 2018). One paper argued that general

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[7] Data sourced from table 16.8 in section 16 of the Report on Government Services 2021 available at: www.pc.gov.au/research/ongoing/report-on-government-services/2021/community-services/child-protection

practitioners (GPs) are especially well positioned to detect early and intervene, but that funding for inter-professional collaboration was a 'challenge' (Jordan and Sketchley 2009).

Siloed funding of government departments, backed up by performance-based budgeting that clearly distinguishes responsibilities so that organisations and managers can be held accountable for outcomes, can discourage collaboration (Davies and Ward 2012). Siloed funding reduces incentives to invest in early intervention programs if their benefits accrue to other agencies (EIF 2018). It can create unnecessary service duplication (Munro 2011), and siloed systems can create path dependencies that become a barrier to change (Bason 2010, cited in OECD (2017). Purchaser-provider funding of NGOs can have similar effects (Allen Consulting Group 2008).

The National Framework documentation articulated a potential role for the Framework in enabling new approaches to service commissioning, pooled funding and place-based approaches, together with building workforce capacity and capability. However, the evaluation of the Framework found that structural barriers 'challenged' the new approaches to service commissioning and pooled funding (ACIL Allen Consulting 2015). This is consistent with the experience in the UK where the way in which costs are identified varies across areas and no standard formula exists. LSCBs have had to spend considerable time negotiating and securing funding (Wood 2016).

Procurement and the vision

How service agreements with government agencies and contracts with NGOs are specified affects incentives and, through them, the transition to the public health approach. Evidence for this review identified ways in which approaches to procurement can impede the shift to the public health approach. Funding agencies to meet objectives that are specific to them, rather than system-wide, can discourage collaboration. Output-based funding encourages the production of outputs that may not be linked to desired system-wide outcomes, or that, if they are linked, are not sufficient to achieve the outcomes.

Short-term contracts affect the capacity to attract and retain suitably qualified staff, particularly in remote areas. Several papers suggested that funding for prevention and early intervention initiatives was not enough, or too short term in nature, sometimes making it difficult to achieve the required outcomes and to attract (or hold on to) staff. For example, Letourneau et al. called for increased funding in the US to enable the public health approach, and Sanders and Calam argued that short-term funding and employment contracts are 'not ideal' (Letourneau et al. 2014; Sanders and Calam 2012). Heavy caseloads caused by funding constraints can be a source of 'burn out' that leads to staff turnover. This reduces the capacity to deliver quality services and can work against collaborative working styles because staff have less time and tenure in their positions to build relationships.

In a constrained budget environment, pressure to meet immediate priorities may allow little time to embed a new service or to demonstrate positive impact. Piloting and evaluating a new long-term investment fund, including funding for system-wide changes such as to

improve how agencies work together, is one approach that has been suggested for avoiding these constraints and to enable understanding of what effective early intervention can achieve when all necessary conditions are in place (EIF 2018).

Social impact bonds (SIB) are another approach, which has been used to attract patient private capital into child protection projects and to strengthen incentives to produce outcomes. So far, they have aimed to address issues at a relatively late stage of intervention, but the market is developing and there are opportunities to explore SIB financing of earlier intervention (Griffiths and Meinicke 2014).

Building the capability to deliver the vision

The public health approach to protecting children relies heavily on its workforce. Workers need the skills and capacity to deliver a sufficient quality and quantity of interlinked services, in the locations and settings that they are required, and as early as possible. In addition, decision-makers at all levels need the requisite knowledge and training to guide implementation.

Many studies from Australia, the US, and the UK identified problems recruiting or retaining front line workers (Bessarab and Crawford 2010; Brandon et al. 2008; Broadley 2018; Davies and Ward 2012; Jordan and Sketchley 2009; Lewig, Arney and Salveron 2010; Roylance 2010; Sanders and Calam 2012; Sanders, Prinz and Shapiro 2011; Shapiro, Prinz and Sanders 2010; Sun and Buys 2013). Existing workforce problems are exacerbated in the public health approach because it changes the mix of staff — it eases pressure on tertiary services in the long term, but in the short term it increases demand for suitably skilled workers in primary and secondary prevention services.

Studies identified a shortage of front line workers across secondary and tertiary services, particularly in remote locations, or areas where workers may not want to live. For example, Bessarb and Crawford (2010); Broadley (2018); and Sanders, Prinz and Shapiro (2011) identified problems recruiting or retaining staff to work with Aboriginal or Torres Strait Islander families in remote parts of Australia. The Working Group on Child Maltreatment Prevention in Community Health Centres (2009) identified similar problems recruiting and retaining staff to work in 'remote or undesirable locations' in the US. Bessarab and Crawford (2010) considered that hiring local workers could improve staff retention, cultural capability, and service quality.

Several studies linked working conditions (for example, caseload size and secure funding and support) and staff retention rates. In Australia, Jordan and Sketchley (2009, p. 3) identified the risk of 'an erosion of the child protection workforce due to high levels of stress, resulting in high staff turnover and staff shortages'. Brandon et al. (2008, p. 318) attributed high staff turnover in the UK to 'overwhelming workloads'.

Studies in Australia, the US and the UK have recommended better management of caseloads, although few elaborated on how this should be achieved in practice. A number of studies pointed out that changes to staffing practices may be difficult to achieve given current funding

levels (Asawa, Hansen and Flood 2008; Child Welfare Information Gateway 2013; Churchill and Fawcett 2016; Davies and Ward 2012; Fernandez 2007; Sanders and Calam 2012).

Bessarab and Crawford (2010) noted that training could help improve performance and reduce burnout. For example, Hanson et al. (2008) reported findings from a study in one US State that less than 30 per cent of suspected child abuse cases known to school personnel are reported, although this improved with training. Other studies reported that teachers did not feel adequately prepared to either understand or educate children about sexual victimisation, or that education workers lacked training in recognising or responding to signs of child maltreatment (Lumsden 2014; Rheingold et al. 2015; Wurtele 2009). Similar issues were identified in the health sector. For example, in one Australian study, one-third of paediatricians reported receiving no training at all in child protection (Sun and Buys 2013), and a US-focused study reported that, even among nurses who were trained to recognise child maltreatment, there was uncertainty around what constituted a health concern and unfamiliarity with referral options (Skybo and Polivka 2007). Several other studies from the US and the UK also identified health sector training needs (Anthony, Austin and Cormier 2010; Appleton 2011; Fifield and Blake 2011).

Some types of training — especially those that facilitate a shift in focus towards prevention or early intervention — are particularly important to enable the public health approach. Training was identified as a means of increasing the capacity of the existing universal services workforce (including childcare workers, teachers, and healthcare professionals) to prevent child maltreatment (for example Hanson et al. (2008); Mathews et al. (2017); O'Donnell, Scott and Stanley (2008); Sanders, Prinz and Shapiro (2011); Sun and Buys (2013) and others). Studies identified a need for training to increase understanding of the linkages between different types of family violence (Herrenkohl et al. 2015), between child maltreatment and other social issues (Davies and Ward 2012), and to increase cultural competence (Asawa, Hansen and Flood 2008; Bessarab and Crawford 2010; Broadley 2018; Damashek et al. 2011; Lewig, Arney and Salveron 2010; McLeigh et al. 2017; Scott, Lonne and Higgins 2016; Self-Brown et al. 2011; Tasmanian Department of Premier and Cabinet 2013; Working Group on Child Maltreatment Prevention in Community Health Centers 2009).

Developing a learning process that encourages continuous improvement rather than a blame culture

Uncertainty is a central feature of child protection work, including about the facts of the case and how to interpret them. Hence an important system design issue is how to assist those involved in child protection to handle uncertainty (Munro 2010).

One aspect of this is how the system handles decisions that with the benefit of hindsight appear to have been wrong. Major reviews of decisions are often prompted by significant failures, usually the death of a child. However, it can be difficult to untangle whether the cause was unprofessional practice or reasonable decisions made in the context of uncertainty and unpredictable circumstances. Concerns that they will be blamed for their professional judgements can encourage defensive behaviour such as being compliant with rules rather

than exercising judgement (Munro 2010). This can lead to a risk averse culture, which can hold back the public health approach by making a statutory response seem safer than prevention (Bromfield and Holzer 2008). If attitudes to risk differ across the system, those who are more risk averse may avoid risk by being reluctant to act (Davies and Ward 2012; Jordan and Steelman 2015) and/or referring responsibility for the child and family to another sector (Davies and Ward 2012). In addition, the difficulties of applying secondary approaches to complex cases — reinforced by concerns about expertise and resources — can trigger a statutory approach (Barlow and Calam 2011; Oates 2015).

There are concerns that assessment frameworks can encourage compliance-based approaches that under-value professional judgement. Studies suggested that the use of risk assessment tools may increase risk averse behaviour by professionals (Bromfield 2012) and that subjective interpretations of assessment tools could lead to different findings about the level of risk (Valentine and Katz 2015). Finding the appropriate balance between objective performance assessment metrics and professional judgement is a challenge.

Implications for policy makers

The What Works scoping review method did not distil key themes from the evidence about 'a system that enables a public health approach to protecting children'. Therefore, the Commission did this, by interpreting the evidence to reveal potential barriers and enablers to moving towards a public health approach. This suggested some key issues governments and stakeholders could consider, to build on the momentum that the National Framework is creating.

Adopt a systems way of thinking to analyse the system for protecting children

A systems way of thinking provides a useful analytical framework for policy makers to use to develop policies and approaches for improving the system for protecting children.

Efforts to improve child safety occur within complex systems, in which the extent and form of collaboration between system participants affect the outcomes for children. Policy development therefore needs to consider systemic interdependencies. It also needs to recognise that policy problems in child protection are 'wicked': difficult to define clearly, with many interdependencies and causes, are often not stable, usually have no clear solution, are socially complex and rarely sit within the responsibility of one organisation (Allen Consulting Group 2008).

A holistic approach to developing policies can be effective in these circumstances:

> The handling of wicked problems requires holistic rather than linear thinking. This is thinking capable of grasping the big picture, including the interrelationships between the full range of causal factors and policy objectives. Critically, tackling wicked problems also calls for high levels of systems thinking. This big picture thinking helps policy makers to make the connections

between the multiple causes and interdependencies of wicked problems that are necessary in order to avoid a narrow approach and the artificial taming of wicked problems (APSC 2007).

Systems thinking is increasingly being promoted as a holistic framework for resolving complex public policy problems (APSC 2007; Munro 2010, 2011; Noveck and Glover 2019; OECD 2017; Stroh 2015).

Understanding a system's boundaries, how its components interact, the feedback loops between them, and the roles and funding decisions of different levels of government, would provide a firmer basis for reviewing system strengths and weaknesses and for understanding the impacts of policy changes. A systems analysis would consider how individual policy interventions will be offset or reinforced by the wider system. Recognising the interdependencies between system participants would improve understanding of how to encourage collaboration between them. It should also contribute to filling a gap in knowledge identified by the EIF (2018), about how culture, leadership, vision and partnership working can build a wider system to support effective early intervention.

The Munro review of child protection in the UK used systems thinking to explain how current conditions evolved, why previous reforms failed and contributed to new problems, and how to improve the system. The review considered not only the initial effects of proposed reforms, but also how they interact with the rest of the system through feedback loops that unintentionally reinforce some aspects of practice while downplaying others. Government directives interact, often in surprising ways, with local factors so that the end result may be far from what was intended. While previous reviews recognised that reforms could have unintended consequences, they assumed that more control and central systems were needed to manage them, leading to an over-bureaucratised system (Munro 2011).

By deepening the understanding of system interconnections, systems thinking can identify changes that work together to improve outcomes, while reducing the risk of unintended consequences. This acknowledges that individual reforms may not work in isolation.

A key challenge is to develop a level of analysis that is simple enough to be understood and complex enough to capture diverse relationships. Stroh (2015) describes six approaches, of varying complexity, that can be used to achieve this balance. One is system mapping. This may not involve mapping an entire system, which can be 'an unbounded task that produces confusion and paralysis in the name of comprehensiveness'. Rather, the purpose is to answer a focusing question that can yield actionable insights (Stroh 2015, p. 84). Systems thinking might be used to analyse part of a state or territory unit, and confined to a subject matter of interest (for example, referral processes) to make the task more manageable.

Systems thinking, by developing a deeper understanding of how the child protection system works, can suggest more durable improvements. However, progress towards an improved system may be slow, given that there are many system participants and the relationships between them are complicated, the need to develop new skills and ways of working, and the diverse norms and values across the system. Systems approaches require working across organisational boundaries and government levels (OECD 2017). Moreover, the system must

keep operating at the same time as it is being changed. Transformational change — such as moving to a public health approach — may be achieved incrementally. Change must be 'at once sympathetic and disruptive to the old system; incrementalism must be married to a whole systems framework' (OECD 2017, p. 23).

Achieving change will continue to pose challenges for policy makers and governments, faced by ongoing calls for resources, while evidence of the benefits comes slowly. There will be temptations to abandon reform or to drive change through more government direction and prescription.

Re-confirm the vision

Given that a shared vision can make it easier to achieve change, it is useful to confirm periodically that the vision is still widely accepted. Re-confirming the vision would help to provide new energy and commitment, particularly if it was supported by governments accepting accountability for ensuring compliance with the objectives, as the Senate Community Affairs Committee Secretariat (2015) recommended should happen in the third action plan for the National Framework.

A review of the membership of leadership groups involved in the National Framework processes could be part of a re-confirming process. As noted, there is a view that the predominantly child protection and out-of-home care agency membership of leadership groups drives an excessively tertiary focus in the National Framework. There was broad support in the second National Framework evaluation for revisiting governance membership to ensure more appropriate representation. The view was that the governance structure needs to include representation from other areas such as health, education and early childhood (ACIL Allen Consulting 2015).

Consultation about the vision should involve children, young people and families who are or have been affected by the system, to gain their insights about possible improvements and to give them an opportunity to influence decisions that influence them. Families Australia — which provides policy advice to governments on behalf of 800 member organisations that work to advance family wellbeing and participation — was commissioned by the Australian Government Department of Social Services in 2019 to consult broadly about a future national plan for children and families, with the associated report released in 2020 (details in the *Addendum* later in this paper).

Improve commissioning

Improving the commissioning process would facilitate progress towards the public health approach.

Researching the population and its needs

This review found that collecting and sharing high quality data on prevalence and outcomes is important but mostly inadequate. Generating and sharing better data about risk factors for abuse and neglect, the prevalence and incidence of abuse and neglect, and about the outcomes of child protection activities should be a priority. This would provide:

- more evidence about whether outcomes are improving, which would help to build public support for the public health approach

- information about which parts of the system require research and policy attention

- a firmer basis for allocating funds between primary, secondary and tertiary services and between locations

- a stronger basis for developing performance frameworks, which could be used to strengthen accountabilities and to drive continuous improvement.

The size of these benefits is difficult to predict. Opportunities to use data are largely unknown until the data sources are better understood, and until data users have undertaken data discovery (PC 2017). However, the frequency with which the significance of the evidence base is discussed in the reviewed papers and studies suggests the benefits may be large.

As the National Framework develops, desired outcomes and how to measure them are likely to be discussed. In this regard, the commencement of a five-year study of the prevalence and effects of child maltreatment in Australia provides an opportunity to fill a major data gap. This is the first study to examine the health outcomes and burden of disease caused by child maltreatment (ACMS nd).

It is important to reduce barriers to sharing data. Some barriers — such as the absence of a 'common language' — could be reduced by agreement between jurisdictions. The development by the Australian Government of new public sector data sharing and release legislation may provide opportunities to reduce other barriers (Department of the Prime Minister and Cabinet 2019).

Clarifying roles and responsibilities for implementing the vision

Many different agencies and NGOs are involved in providing primary, second and tertiary services for protecting children. This creates a risk that duplication of roles may lead to excessive complexity for service users and unnecessary spending.[8] Overlapping or unclear roles would also reduce accountability. More clearly defining roles and responsibilities would reduce these problems.

However, if this involves changing ingrained practices that have developed over time, simply changing role specifications may not be effective. Bringing behaviour into line with re-specified roles may require adjusting norms and values. Strategies that could be useful

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[8] Some overlapping of responsibilities may be needed to prevent children from 'falling between the cracks'.

include inter-professional training, increasing the involvement of system participants in planning and decision-making, and enhanced use of protocols that codify new roles.

Capabilities to perform re-specified roles are crucial. Studies identified some misalignments of roles and capabilities — for example, additional training of universal service workers being needed in relation to their early intervention role — that would need to be addressed if roles were changed. Resourcing implications would also need to be considered if some roles were enlarged.

Locating decision-making and leadership for achieving the vision

The papers and studies considered in this review gave examples of where decision-making authority is located, but did not consider how the characteristics of different types of decisions affect where they should be made. The subsidiarity principle — that decisions should be made by the lowest competent authority; for example, decisions that affect local areas should be made locally — only provides broad guidance. Some jurisdictions may benefit from more detailed guidance that they could use to review whether decision-making authority has been allocated efficiently.

Organisational and workplace arrangements

This review found examples of organisational arrangements that can avoid the risk of fragmentation and encourage coordination, but did not identify best practice. While this may be because in some cases these arrangements have to be designed to suit local conditions, jurisdictions may still be able to learn from the experience of others.

Build the skill base

Having some experts in systems thinking — possibly in the policy areas of government departments — would be a prerequisite for implementing this approach to system development. Participants in the system would not need this expertise. However, training about system complexity may help people to understand how different roles interact and how the way that they perform their roles affects the performance of other roles.

Review approaches to funding

As progress towards the public health model depends in part on funding, a stocktake of how different jurisdictions approach funding would be useful. This could consider:

- the basis on which funds are allocated between primary, secondary and tertiary services; how the benefits from funding services are measured and compared; additional data that would strengthen the basis for comparison; and unnecessary barriers to moving funds between services

- opportunities for new sources of funding, such as non-government funding through social impact bonds

- whether there is unconscious bias in the funding process

- whether the structure of funding of agencies and of non-government providers encourages collaboration, supports families and children and prevents child maltreatment and neglect, encourages system and capability development and appropriate division between current and capital expenditure

- whether funding provides incentives to achieve system goals

- whether procurement processes encourage or discourage open-ended feedback loops that encourage learning (OECD 2017).

Further developing the learning process for continuous improvement

Systems thinking would improve analysis of the causes of system failure, focusing attention on elements of the system that failed rather than on finding scapegoats. This would help to reduce the risk aversion that appears to be common in relation to child protection.

Better supporting priority cohorts

Three issues featured prominently in the studies and papers in this review.

First is the limited involvement of Aboriginal and Torres Strait Islander people in decision-making. A report by the NSW Government (2018) found that the evidence indicated that Aboriginal-specific positions and Aboriginal community-controlled organisations can better reach Aboriginal people and communities. Enablers of success for one model included soft entry points (that is, entering the system without a professional referral), a flexible approach that responds to individual needs, a strengths-based approach, that it is community-driven and with culturally appropriate design.

The second is structural bias against some groups. Screening bias could be reduced — with the benefit of reduced stigmatisation — by establishing a universal base for preliminary identification (Anthony, Austin and Cormier 2010; Barlow and Calam 2011; O'Donnell, Scott and Stanley 2008).

Third, papers identified a shortage of culturally capable workers across secondary and tertiary services, particularly in remote locations, or areas where workers may not want to live. This may particularly affect Aboriginal and Torres Strait Islander families. Some papers suggested that hiring local workers would improve staff retention and improve cultural capability. They also recommended cultural capability training. Another suggestion is the bicultural model involving caseworkers and Aboriginal Family Support Workers working in pairs.

Policy-makers need to be aware of the implications for priority groups whenever they propose changes to the system for protecting children.

Addendum

Two important reports about the National Framework, commissioned by the Australian Government Department of Social Services, have been released since the evidence collection for this review was completed. Some of these reports' themes for improving the Framework overlap with findings from the Commission's research, including the important role of a shared vision, and the benefits from broadening the governance membership, building the outcomes framework, improving capabilities, consulting with those affected by the system, and supporting those with special needs.

Price Waterhouse Coopers: Evaluation of the National Framework for Protecting Australia's Children 2009-2020

Price Waterhouse Coopers (PwC 2020) found that the National Framework has been an important mechanism for national collaboration on protecting Australia's children and reducing child abuse and neglect, but that the outcome of achieving a substantial and sustained reduction in child abuse and neglect remains a significant challenge for Australia.

The opportunities for improvement that PwC identified include:

- focusing the Framework on a defined cohort of vulnerable children[9]

- considering broader membership of the National Framework governance structure

- adopting an outcomes framework (including short-term outcomes), supported by a national prevalence study on child abuse and neglect to set an accurate baseline

- independent monitoring and reporting to ensure accountability and measurement of progress

- involving children, families and communities in informing the priorities of the successor plan to the National Framework.

Families Australia: Beyond 2020: Towards a successor plan for the National Framework for Protecting Australia's Children 2009–20

Families Australia led national consultations on the successor plan. The findings from these consultations (Families Australia 2020) included that the successor plan should:

- broaden action beyond child protection departments and their ministers to engage all relevant portfolios, particularly education, health, and early childhood, working in true collaboration around a common goal

- be based on a coherent narrative framed around child wellbeing, including safety and protection but emphasising prevention

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9 As noted in this review, there is a risk of screening bias when focussing on specific groups. So caution is required to ensure other system components are also addressed such as having a shared vision, skilled workforce and solid commissioning processes.

- contain a shared outcomes framework for universal and targeted services supporting children, young people, parents and families that explicitly links their role and focus with outcomes under the successor plan and aligns funding with implementation cycles

- focus on priority issues where a concerted national approach will deliver the greatest impact in the shortest possible time

- intensify the focus on priority cohorts. For example, strengthen efforts to address the over-representation of Aboriginal and Torres Strait Islander children, young people, families and communities in child protection systems

- strengthen the public health approach begun under the National Framework, including through better leveraging and coordinating investments by all governments in universal and targeted supports

- strengthen progressive universalism as part of this approach by linking universal service delivery platforms with the delivery of supports to targeted populations

- further develop the capability of the cross-sectoral workforce to strengthen protective factors and address adverse childhood experiences.

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