“Give Sorrow Words” - A Language for Healing

Take Two Second Evaluation Report
A partnership between Berry Street Victoria, Austin Child and Adolescent Mental Health Services, La Trobe University School of Social Work and Social Policy and Mindful.
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Associate Professor Margarita Frederico from School of Social Work and Social Policy, La Trobe University is the Principal Consultant of the research and evaluation of Take Two. Annette Jackson is the Research Manager, Take Two (Berry Street Victoria) and is located at La Trobe University. Carly Black is the Senior Research Officer, Take Two (Berry Street Victoria) and is also located at La Trobe University.

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# Table of contents

Acknowledgements ........................................................................................................................................... i
Who are the evaluators? ................................................................................................................................... ii
Table of Contents ........................................................................................................................................... iii
List of Tables .................................................................................................................................................. vi
List of Figures ................................................................................................................................................. vii
Executive Summary ........................................................................................................................................ xi

## Chapter 1: Introduction

1.1 Description of Take Two and its context ................................................................................................. 1
1.2 Structure of the report ............................................................................................................................... 3

## Chapter 2: Evaluation design and methodology

2.1 Overview ................................................................................................................................................... 5
2.2 Outcomes framework ................................................................................................................................. 7
2.3 Stakeholder surveys ................................................................................................................................. 13
2.4 Take Two clinician surveys .................................................................................................................... 15
2.5 Descriptive data of client group ............................................................................................................. 16
2.6 Analysis of speech and language development .................................................................................... 16
2.7 Staff journal analysis and case studies .................................................................................................. 17
2.8 The Secure Welfare Service focus group ............................................................................................ 17
2.9 Statistical analysis .................................................................................................................................... 17
2.10 Limitations .............................................................................................................................................. 17
2.11 Summary ................................................................................................................................................. 18

## Chapter 3: Ongoing implementation of Take Two - The second year

3.1 Overview ................................................................................................................................................ 19
3.2 The first year .......................................................................................................................................... 19
3.3 Overview of the second year ................................................................................................................ 19
3.4 Practice Framework ............................................................................................................................... 21
3.5 Spotlight on the Take Two Aboriginal team ....................................................................................... 22
3.6 Spotlight on the Take Two Secure Welfare role ............................................................................. 23
3.7 Contributing to service system improvement ..................................................................................... 25
3.8 Training received by Take Two in 2005 ............................................................................................ 28
3.9 Summary ................................................................................................................................................. 29

## Chapter 4: Who are the children and young people involved with Take Two?

4.1 Overview ................................................................................................................................................ 31
4.2 An overview of the cases accepted and closed by Take Two in 2004-2005 ....................................... 31
4.3 Description of the children involved in the Take Two program ....................................................... 35
4.4 Children’s experiences within the protection and care system ....................................................... 37
4.5 Young people within the Take Two Secure Welfare Service ........................................................... 41
4.6 Child’s experience of abuse and neglect ............................................................................................. 44
4.7 The consequences of abuse and neglect ............................................................................................ 48
4.8 Summary ................................................................................................................................................. 53

## Chapter 5: Interventions - How did Take Two and other services intervene with these children and young people?

5.1 Overview ................................................................................................................................................ 55
5.2 Desired outcomes of Take Two involvement according to referrers ............................................. 55
5.3 Interventions with children, families, carers and the broader system .......................................... 55
5.4 Other service systems involved .......................................................................................................... 63
5.5 Consultations ......................................................................................................................................... 65
5.6 Summary ................................................................................................................................................. 66

## Chapter 6: Children’s stories

6.1 Overview ................................................................................................................................................ 67
6.2 The analysis of case studies ................................................................................................................ 67
6.3 The family picture ................................................................................................................................. 67
6.4 The children’s presentations ............................................................................................................... 69
6.5 Child protection and care involvement ............................................................................................. 70
6.6 What happened to the children? ....................................................................................................... 72
6.7 How does Take Two intervene? ......................................................................................................... 77
6.8 Case study outcomes ............................................................................................................................ 83
6.9 Summary ................................................................................................................................................. 92

List of Tables

Table 1  Take Two Child Outcomes Framework and Measures ................................................................. 8
Table 2  Sources of Different Types of Data for the Take Two Client Group used by this Evaluation ...................... 16
Table 3  Summary of Implementation Issues and Program Developments during 2005 ................................. 20
Table 4  Comparison between the Secure Welfare Service in Victoria, Australia and Trillium Family Services in Oregon, USA ............................................................. 24
Table 5  Cases Accepted and Closed by Take Two Team in 2004 and 2005 .............................................. 32
Table 6  Daily Average of Cases Open each Quarter by Take Two Team in 2004 and 2005 .............................. 33
Table 7  Aboriginal Children Referred to Take Two by Type of Team in 2004 and 2005 ............................... 36
Table 8  Number of Siblings for all Take Two Clients in 2004 and 2005 ......................................................... 36
Table 9  Means, Standard Deviations and ANOVAs regarding Child Protection Involvement and Age of all Take Two Clients in 2004 and 2005 ................................................................. 38
Table 10 Placement at Time of Referral for all Take Two Clients in 2004 and 2005 ........................................ 40
Table 11  Child Protection Case Plan Goals for all Regional and Aboriginal Teams’ Clients in 2004 and 2005 .... 41
Table 12  Age at Time of Admission to Secure Welfare Service for Secure Welfare Take Two Clients and for the General Secure Welfare Service Population in 2004 and 2005 ................................. 41
Table 13  Child Protection Region for Take Two Secure Welfare Cases in 2004 and 2005 .............................. 42
Table 14  Number of Admissions to the Secure Welfare Service for Secure Welfare Take Two Clients in 2004 and 2005 .............................................................................................................. 43
Table 15 Total Days Placed in the Secure Welfare Service for Secure Welfare Take Two Clients in 2004 and 2005 44
Table 16 Incidence of Abuse or Neglect during Take Two Involvement for Open Cases in 2005, not including Secure Welfare, according to Take Two Clinicians (N = 352) .................................................. 47
Table 17 Mental Health Diagnoses according to Take Two Clinicians for Take Two clients, not including Secure Welfare, for 2004 and 2005 ............................................................................................................... 50
Table 18 Enrolment in School at Time of Referral for Take Two Clients aged six years and older in 2004 and 2005 51
Table 19 Examples of Hearing, Speech and Language Concerns for Sample of School-age Children involved in Take Two in Early 2005 (N = 108) ........................................................................................................ 52
Table 20 Desired Outcomes at Time of Referral to Take Two according to Referrer for Regional and Aboriginal Teams’ Clients in 2004 and 2005 ................................................................................................. 56
Table 21 Overview of Types of Services Provided for Take Two Regional and Aboriginal Teams’ Clients in 2004 and 2005 .......................................................................................................................... 59
Table 22 Type of Direct Service Provided for Take Two Regional and Aboriginal Teams' Clients in 2004 and 2005 58
Table 23 Location of Service Provision for Take Two Regional and Aboriginal Teams’ Clients in 2004 and 2005 . 58
Table 24 Interventions by Take Two Regional and Aboriginal Teams for Open Cases in 2005 ....................... 59
Table 25 Type of Services Working with Children during Take Two Involvement for Regional and Aboriginal Teams’ Open Cases in 2004 and 2005 (N = 330) ................................................................. 63
Table 26 Consultations Provided by Take Two Team in 2005 ...................................................................... 66
Table 27 Number of Social Network Maps Completed during Take Two Involvement (N = 53) ................. 93
Table 28 Number and Percentage of SDQs Completed at Different Stages during Take Two Involvement in 2004 and 2005 ........................................................................................................................................ 111
Table 29 Baseline Data: Percentage of Children and Young People in the Normal, Borderline and Clinical Range on Scales of the SDQ as Reported by Young People, Parents, Carers and Teachers ................................. 113
Table 30 Baseline Data: Overall Difficulties Ratings on the Strengths and Difficulties Questionnaire (SDQ) as Reported by the Young Persons, Parents, Carers and Teachers ......................................................... 114
Table 31 Baseline Data: Responses to the SDQ Question ‘How Long have these Difficulties been Present?’ as Reported by the Young Persons, Parents, Carers and Teachers ................................................................. 114
Table 32 Baseline Data: Percentage of Children and Young People in the Normal, Borderline and Clinical Range on the Impact Score of the Strengths and Difficulties Questionnaire (SDQ) as Reported by the Young Persons, Parents, Carers and Teachers ................................................................. 115
Table 33 Baseline Data: Responses to the SDQ question ‘Do the Difficulties put a Burden on You or the Family?’ as Reported by the Young Persons, Parents, Carers and Teachers ......................................................... 115
Table 34 Percentage of Children and Young People in the Borderline and Clinical Range on Scales of the Strengths and Difficulties Questionnaire (SDQ) at Baseline and Follow-up ......................................................... 117
Table 35  Questions on the Follow-up SDQ relating to whether Take Two Intervention has been Helpful............... 119
Table 36  Number of TSCCs completed at different stages during Take Two involvement (N=160 TSCCs by 116 children)............................................................................................................................................ 121
Table 37  Comparing the Mean T scores of the TSCC Scales across Time 1 and Time 2 (n=24) ......................................................................................................................... 124
Table 38  Percentage of Children in the Clinical Range of the TSCC Scales at Time 1 and Time 2 (n=24) .......................................................... 125
Table 39  Responses to Stakeholder Survey relating to Satisfaction with Take Two.......................................................... 128
Table 40  Responses to Stakeholder Survey relating to Perception of Outcomes for the Child.......................................................... 131
Table 41  Stakeholder Survey relating to Satisfaction and Percentage of Outcomes for the Child (N=19) .......................................................... 133
Table 42  Responses from Children regarding what was Helpful about Take Two...................................................................................... 134
Table 43  Responses from Children regarding what could be Improved about Take Two.......................................................... 136
Table 44  Client Change as Rated by Take Two Clinicians for Cases Open in 2005, not including Secure Welfare.. 144
Table 45  Parent Change as Rated by Take Two Clinicians for Open Cases in 2005, not including Secure Welfare. 144
Table 46  Carer Change as Rated by Take Two Clinicians for Open Cases in 2005, not including Secure Welfare... 145
Table 47  School Change as Rated by Take Two Clinicians for Open Cases in 2005, not including Secure Welfare 145
Table 48  System Change as Rated by Take Two Clinicians for Open Cases in 2005, not including Secure Welfare 146
Table 49  Means and Standard Deviations for Responses to the Clinicians Surveys Regarding Client Outcomes for Open Cases in 2005, not including Secure Welfare ............................................................................................... 147
List of Figures

Figure 1. A map of Take Two clinical locations in 2005 ................................................................. 2
Figure 2. The Take Two partnership and teams .................................................................................. 3
Figure 3. The Take Two evaluation framework ................................................................................... 6
Figure 4. The social network circle (Part 1 of the Social Network Map) .............................................. 11
Figure 5. The social network grid (Part 2 of the Social Network Map) .............................................. 12
Figure 6. Take Two’s therapeutic grid as presented in the Take Two clinician survey .......................... 15
Figure 7. Age and gender for all Take Two clients in 2004 and 2005 (N = 585) ...................................... 15
Figure 8. Previous Child Protection involvement at time of referral for all Take Two clients in 2004 and 2005 (N = 553) 37
Figure 9. Type of Protective Order at time of referral for all Take Two clients in 2004 and 2005 (N = 561)........ 38
Figure 10. Previous placements at time of referral for all Take Two clients in 2004 and 2005 (N = 554) .......... 39
Figure 11. Percentage of reunification attempts for children in out-of-home care prior to referral to Take Two in 2004 and 2005 (N = 510) ........................................................................................................ 39
Figure 12. Type of maltreatment according to the Harm Consequences Assessment prior to referral for all Take Two clients in 2004 and 2005 (N = 558) ........................................................................................................ 45
Figure 13. Examples of maltreatment according to the Harm Consequences Assessment prior to referral for all Take Two clients in 2004 and 2005 (N = 560) ........................................................................................................ 46
Figure 14. Number of types of maltreatment according to the Harm Consequences Assessment prior to referral for all Take Two clients in 2004 and 2005 (N = 558) ........................................................................................................ 46
Figure 15. Number of types of consequences of maltreatment according to the Harm Consequences Assessment prior to referral for all Take Two clients in 2004 and 2005 (N = 555) .................. 48
Figure 16. Examples of consequences of maltreatment according to the Harm Consequences Assessment prior to referral for all Take Two clients in 2004 and 2005 (N = 560) ........................................................................................................ 49
Figure 17. Consultations provided by Take Two by age of children in 2005 (N = 1590) ............................ 66
Figure 18. History of protective involvement for a 5-year-old girl .......................................................... 71
Figure 19. History of protective involvement for a 7-year-old girl .......................................................... 71
Figure 20. History of protective involvement for a 11-year-old boy ......................................................... 71
Figure 21. History of protective involvement for a 15-year-old girl .......................................................... 71
Figure 22. History of protective involvement for a 15-year-old boy .......................................................... 71
Figure 23. Social Network Map - Andrew 16 years of age ................................................................. 94
Figure 24. Proportion of people in each area in the child’s life (N = 26 baseline social network circles) ........ 95
Figure 25. Proportion of people listed as ‘the most important’ in each area in the child’s life (N = 31 baseline social network grids) ........................................................................... 95
Figure 26. Children’s perception of level of closeness of their carers (N = 26 children and 42 carers N = 41) ...... 96
Figure 27. Children’s perception of the length of time they have known their carers by type of carer (N = 24) ...... 97
Figure 28. Social Network Map - Cameron 11 years of age ............................................................... 98
Figure 29. Number of children living with a sibling, comparing data from the DHS-Client Profile Documents and the Social Network Maps completed by the children (N = 28) ................................................................. 99
Figure 30. Frequency of times children saw at least one type of family member, according to the children (N = 28) 99
Figure 31. Social Network Map - Matthew 12 years of age ............................................................... 100
Figure 32. Social Network Map - Jennifer 12 years of age ............................................................... 101
Figure 33. Number of friends listed by children (N = 77 friends by 29 children) ......................................... 102
Figure 34. Percentage of children’s descriptions of the types and level of support they received from friends (N = 23 children; 77 friends) ........................................................................... 103
Figure 35. Social Network Map - Louise 12 years of age ................................................................. 104
Figure 36. Social Network Map - Simon 13 years of age ................................................................. 105
Figure 37. Mean percentage of people described in children’s Social Network Map as ‘very close’ over two time periods (N = 10) ........................................................................... 106
Figure 38. Mean percentage of people described in children’s Social Network Maps as ‘not very close’ over two time periods (N = 10) ................................................................. 107
Figure 39. Social Network Map - Neil at 11 years then 12 years of age .......................................................... 108
Figure 40. Baseline data: Number of SDQ scales at the borderline and clinical range according to young persons, parents, carers and teachers (N = 319) .......................................................... 112
Figure 41. Mean SDQ total difficulties score at time 1 and 2 by type of respondent (N = 85) .............................. 118
Figure 42. Baseline data: Percentage of children reporting in the clinical range on each of the scales in the TSCC (N = 92) .................................................................................................................. 123
Figure 43. The percentage of each respondent type to the stakeholder survey (N = 274) .................................................. 127
Figure 44. Responses to the question 'How would you grade the service received from Take Two?' (N = 171) ..... 128
Figure 45. Percentage of respondents who agreed with one or more of four questions relating to how the Take Two program was experienced ........................................................................................................ 129
Figure 46. Percentage of responses to 'Take Two helped the child/young person with their life' by length of Take Two involvement (N = 201) .................................................................................................................. 130
Figure 47. Percentage of responses to 'The child gets along better with family members' by length of Take Two involvement (N = 199) ........................................................................................................... 131
Figure 48. Percentage of responses to 'The child gets along better with friends and others' by length of Take Two involvement (N = 199) .................................................................................................................. 132
Figure 49. Trauma presentation and stability of placement, according to Take Two clinicians for cases open in 2005 (N = 341) ........................................................................................................................... 141
Foreword

The second year of Take Two operation could be characterised as a remarkably stable year. During 2005 we allowed ourselves some self-congratulation: for getting our statewide clinical program from start-up in the latter months of 2003 to full and effective operation from the beginning of 2004. The diverse workforce recruited to Take Two had brought a focused commitment to children who have suffered abuse and/or neglect and a range of clinical skills that had been crafted from employment experiences in child mental health services, child protection services and child welfare services. Whereas the impetus of our program during 2004 could largely be attributed to an enthusiasm for the new, the energy of our second year focused around program consolidation.

Our challenge during 2005 was to create a genuine treating team; cross-connecting clinical staff scattered in small teams across Victoria, and integrating their work with our research, training and administrative functions. We built our sense of program identity by requiring all staff, no matter how geographically remote they were nor how clinically busy they were, to participate regularly in a Friday Focus day of professional development. Our most remote staff member was flown to Melbourne for this regular developmental day, and all country staff were offered a night of motel accommodation immediately prior to or following each Focus. Through the Friday Focus we commenced the process of laying the foundations for a common Practice Framework that could characterise the way we address the needs of each child referred to us and the needs of those who care for our clients.

With its inbuilt capacities for formal and reflective evaluation, and for training to its learnings, the Practice Framework developed by Take Two will always be dynamic. During 2005 we were able to start to form connections with international colleagues providing therapeutic services to abused children, and through our own program evaluation we were able to commence a more systematic profiling of client needs and the needs of those who care for our clients. Ultimately, the diagnostic formulations we construct through our clinical assessments and the therapeutic interventions we make into the lives of our clients must be open to scrutiny and formal review. This second Evaluation Report introduces friends and colleagues from allied services to the client outcomes methodology we are seeking to embed within our practice.

The stability and comparative program coherence of Take Two during its second year of operation were mirrored at all levels. The Take Two program was increasingly integrated into the organisational functioning of Berry Street Victoria, and the Take Two Partnership of Berry Street Victoria, Austin Child and Adolescent Mental Health Service, School of Social Work and Social Policy, La Trobe University and Mindful (Centre for Training and Research in Developmental Health) continued to provide the program with committed and coherent oversight. The Take Two Research Team led by Margarita Frederico also prospered as a stable and high-morale team; the productive capacities of the team being well reflected in the high quality of this second Evaluation Report. I again congratulate the principal authors of this report - Margarita Frederico, Annette Jackson, Carly Black, and the wonderful team they have gathered in the School of Social Work and Social Policy, La Trobe University - on their achievement in this report. I thank all the principled and hard-working people who contributed to the consolidation of Take Two during 2005: the staff team; the protective case workers and managers and other services who identified children in need of the program and referred them to Take Two; Berry Street Victoria and its full staff group; the Take Two Partners who help Berry Street Victoria to govern this particular clinical program within the broader organisation; and the many workers, carers and family members who are working so collaboratively with Take Two clinical staff to the purposes of better health outcomes for vulnerable children.

Ric Pawsey
Director Take Two
Executive Summary

“Give Sorrow Words”\(^1\) - A Language for Healing

The impact of severe abuse and neglect affects the child's whole wellbeing and development. The findings presented in this report highlight the effects of severe abuse and the complex interventions required to assist children who experience it. The phenomenon is explored and analysed in this second of three evaluation reports of Take Two. Take Two is a therapeutic service for infants, children and young people who have been traumatised by abuse and/or neglect and who are Child Protection clients. Take Two is formed by a partnership with Berry Street Victoria; Austin Child and Adolescent Mental Health Service (CAMHS); School of Social Work and Social Policy, La Trobe University; and Mindful (Centre for Training and Research in Developmental Health). Take Two is funded by the Victorian Department of Human Services (DHS).

The Victorian Government's integrated strategy is to promote child wellbeing, prevent harm and improve service response to children in the child protection system. More recently, Take Two operates in the context of the introduction of the Child Wellbeing and Safety Act 2005 and the Children, Youth and Families Act 2005 and a number of policy and service system changes which have occurred over the past two years in Victoria.

The evaluation seeks to identify if Take Two delivers effective assessment and therapeutic interventions to at-risk children. It also examines whether Take Two effectively engages elements of the service system to support those interventions and contribute to more positive outcomes for the children.

The program narrative continued in this second stage of the evaluation expands upon data presented in the first evaluation and builds upon the description of the client group (Frederico, Jackson, & Black, 2005). Data from 2004 and 2005 are presented to provide an overview of the program and where appropriate, comparisons are made between the two years. This report also presents a description of the interventions utilised by Take Two and provides a preliminary look at the outcomes data from the program. Underlying the client and system specific findings is demonstration of the value of the Take Two partnership. The partnership provides the foundation to intervene in the breadth and depth of the complex world of children who have suffered severe abuse.

The evaluation approach

The evaluation of Take Two is the ongoing responsibility of La Trobe University, represented by Associate Professor Margarita Frederico, Head, School of Social Work and Social Policy as Principal Consultant; and the Take Two Research team. The research team was led by Annette Jackson, Research Manager, in conjunction with Carly Black, Senior Research Officer, Take Two. The evaluation has been guided by the Take Two Research Advisory Committee (T2RAC) and Research Executive.

A framework for the evaluation was presented in detail in the first evaluation report (Frederico, Jackson, & Black, 2005). The evaluation framework provides the conceptual approach of the action research process and outcome evaluation design. The core concept which guides the evaluation is an in-depth understanding of the child surrounded by four key components of the program. Thus the child, his or her developmental needs and complex formal and informal networks, such as family and carers are the primary focus of attention.

The child's world is also influenced by Take Two which can be understood in four ways: firstly, the conceptual foundation of the program; secondly, an evolving program design; thirdly, multiple levels of assessment and intervention; and fourthly, reflective practice and action learning which includes the integrated and ongoing evaluation strategy. The framework provides the opportunity to study the development and dynamic relationships between each of the components of the program. In keeping with the action research design, the clinical program is actively engaged to ensure the methodology is appropriate for clinical practice. The action research enables findings to be fed back to the program to facilitate ongoing practice and program development.

The action research has also influenced the selection of outcome measures; the development of the Practice Framework used by clinicians; and the expansion of clinical attention regarding the importance of trauma and attachment in interventions.

Multiple data sources are drawn upon to analyse the program and explore outcomes for children. The different sources of data assist in addressing the diversity of variables which are part of the children's worlds and a complex program. The data sources include the referral documents and client activity records. Outcome measures used include Social Network Maps (Tracy & Whittaker, 1999), the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1999) and the Trauma Symptom Checklist for Children (TSCC; Briere, 1996). Other sources of data include staff journals, case studies, stakeholder surveys and clinician surveys. The rationale for using each of these data sources and their relationship to the evaluation are discussed in the report.

Major findings

Who are the children Take Two works with?

Population

In 2004 and 2005, 585 cases were accepted by Take Two. The total number of open cases for 2005 was 462. In 2005 Take Two met 84 percent of the target number of cases, which was 550 cases. An increasing reason for closure of cases was that the intervention had been completed. The age of clients increased from an average of 11 years in 2004 to an average of 12 years in 2005. As in 2004 there were few infant referrals which is a continuing concern given the imperative of intervening as early in life as possible. There was a significant change in the gender ratio of referrals over the two years, with 60 percent being male in 2004 and 40 percent being female in 2005.

1 Malcolm’s counsel from Shakespeare’s Macbeth, Act 4, Scene 3, Line 204-205.
Many children experienced at least one unsuccessful attempt at reunification prior to referral to Take Two. The report notes that many Aboriginal infants or young children were referred to Take Two in 2004 and 2005 which is concerning given the high number of Aboriginal infants referred to Child Protection. Except for the absence of referrals regarding Aboriginal infants, Take Two continued its response to meet the needs of Aboriginal children and their families and there is growing evidence of a culturally driven approach to intervention. For example, a second Aboriginal clinician was appointed in 2005 indicating Take Two’s support of the development of a strong Aboriginal team. Collaborative relationships with Indigenous services such as the Victorian Aboriginal Child Care Agency (VACCA) were an important aspect of Take Two’s work with the Aboriginal community. Culturally sensitive assessment tools were developed by the Take Two Aboriginal team and trained to all Take Two staff. The Aboriginal team also provided consultation to other Aboriginal clinicians working with Aboriginal children to facilitate culturally informed practice.

Characteristics of children
The high level of trauma experienced by both Aboriginal and non-Aboriginal clients of Take Two was also noted in the first evaluation report. A number of disturbing findings in this report include:

- A high degree of loss and grief experienced by many of the children.
- Intergenerational trauma among parents and family networks of many children.
- Multiple forms of abuse were the norm for most of the children.
- Almost all of the children have experienced neglect.
- Most children experienced frequent placement changes prior to referral to Take Two.
- Many children experienced at least one unsuccessful attempt at reunification prior to referral to Take Two.

Social networks
The use of the Social Network Map (Tracy & Whittaker, 1990) provided an opportunity for children to present their perception of their world. The evaluation found that in general Take Two children have limited social networks. The children’s descriptions of their networks frequently highlight an absence of key parental figures. They also illustrate that family and friends are often seen as close to the child but not necessarily helpful. Siblings were a key presence as were extended family members even when they did not live with the child.

In Social Network Maps most children did not list professionals as being part of their close network, although multiple services were involved with many of these children. The role of teachers in offering support was apparent in many of the Social Network Maps.

Strengths and difficulties analysis
The analysis of SDQ reports from multiple sources indicates that most respondents, including the children themselves (aged 11 years or older), reported the children having emotional and behavioural difficulties.

There were different patterns of reporting between young people, carers, parents and teachers. Carers were more likely to report that children were experiencing severe difficulties, followed closely by parents. Teachers reported a more varied response with high level of concerns regarding some problems such as conduct problems and lack of prosocial skills, yet low level of concerns regarding emotional problems. Consistent with other studies, young people reported the lowest frequency and severity of difficulties compared to other respondent types.

Respondents reported that the difficulties experienced by the children affect their daily functioning and place a burden on others, including family, friends and teachers.

Trauma
Over two fifths of children who completed the TSCC scored in the clinically elevated range in one or more scale. This indicated the intra-personal impact of trauma was serious. Feedback from Take Two clinicians suggested that an even higher percentage of children had symptoms that suggested severe intra-personal difficulties due to trauma compared to that shown in the TSCC analysis. The analysis of feedback from clinicians based on the therapeutic grid within the Practice Framework identified three broad approaches to intervention. Firstly, over half the children were described by Take Two clinicians as being traumatised and experiencing low stability of placement. Trauma and deprivation history indicates a need for slow, consistent approaches to intervention but the lack of access to a consistent carer highlights the dilemmas in providing such intervention. Secondly, nearly a fifth of the children were described as having complex trauma presentations but lived in stable placements. These environments enabled the optimal therapeutic interventions, which enlist the involvement of the parent or carer in the child’s process of recovery. Complex trauma histories usually indicate a ‘slow but sure’ approach to intervention is required. Thirdly, a smaller proportion of children had an active but not complex presentation of trauma and high stability of placement. Tailored approaches specific to the trauma events can be utilised in such situations.

New incidents of abuse/neglect
One third of the children had experienced new incidents of abuse and/or neglect whilst clients of Take Two. The majority of these incidents occurred when the child was with family members during access visits or reunification. A
small number, but equally disturbing, occurred in out-of-home care placements. The finding highlights the continued vulnerability of these children and the difficulties in ensuring their safety even when Child Protection has become involved.

Speech and language

A survey of the speech and language needs of a sample of clients of Take Two provided evidence that a high proportion experience speech and language difficulties requiring further assessment. Although speech and language difficulties are known to be an issue for the child protection population, the findings in this report suggest that the difficulties are not always recognised or treated. The survey identified a high number of children with possible speech and language problems which had not been identified by the referrer.

What does Take Two do?

This report begins to explore the nature of the interventions undertaken by Take Two clinicians. A focus on Take Two engaging the children and their network in the therapeutic process is a strong feature of Take Two intervention. Given the high level of trauma and disrupted attachment amongst the client group combined with frequent instability of placement, engagement is an essential stage in intervention. The types of interventions utilised by clinicians are diverse. Although they are described in this report, further study is required before ‘what works’ in respect of interventions can be identified. However, the high level of working with other elements of the children’s system, such as their family, carers, schools and other workers in addition to direct therapeutic intervention with the children, is a major finding of this report. Other findings in relation to Take Two interventions include:

- Ninety-four percent of cases opened by Take Two proceed past preliminary involvement indicating successful engagement with the children and/or their network. This is notable given that children with trauma histories have been reported in the literature as being difficult to engage in therapeutic intervention.
- Less than two percent of cases did not continue after Take Two’s preliminary involvement due to the client or family refusing to engage.
- Take Two’s therapeutic interventions are based upon planned assessments.
- The therapeutic interventions are guided by well-established theories, particularly in relation to trauma and attachment and based on evidence-informed practice knowledge.
- Interventions include individual therapy with the child, interventions with the child and parent or carer, parent and/or carer work and work with other aspects of the service system, such as schools.
- Take Two’s role in establishing or supporting care teams to engage the services involved, such as Child Protection, out-of-home care, schools and other workers; in order to ensure the children’s needs are kept at the centre of all those working towards their best interests.

Interventions to the broader service system included the provision of a Help Desk for workers from Child Protection and VACCA. In addition to the Help Desk, consultations were also provided to these and other services. Training was provided to Child Protection and Community Service Organisations regarding trauma and attachment from both a theoretical and practice perspective.

Take Two has developed a key role in the Secure Welfare Service run by DHS. Feedback from the Secure Welfare Service staff emphasises the value of skilled assessment and opportunities for consultations with Take Two.

Does Take Two make a difference to the wellbeing of children referred?

Although it is too early to provide a definitive answer to this question, the trends in all the outcome measures and other feedback analyses suggest that Take Two has a positive impact on child wellbeing. The plan for Take Two both clinically and for evaluation purposes is to use outcome measures routinely for all clients of Take Two. At this stage of Take Two’s development, the data set regarding outcome measures is small and so caution is required in analysing these trends. However, as Take Two continues to develop a culture of outcomes-based practice, the data is expected to increase over time enabling more detailed analysis in the future. For this evaluation, the focus was more on collecting baseline information and ascertaining if there were some early indications of trends of change for the children.

Outcomes – Social networks

Although there are few Social Network Maps involving repeat measures, they provide an opportunity to consider the findings from a qualitative perspective. In all but two of ten repeat measures, more people were described as being closer to the child in the second or final Social Network Map when compared to the first map. However, for most children more than half the people whom they placed in their Social Network Map were different in each time period. This may reflect changes in their networks or a change in their perceptions of those who are important. On the other hand it may also reflect the instability of placement, or a developmentally driven transition, such as changing from Primary to Secondary school.

Outcome – Strengths and difficulties

There were 85 SDQs completed by the young people, their parents, carers and/or teachers over two or more time periods. The young people, their parents and carers all consistently noted improvement for most of the problem-related scales. However, the only change that was statistically significant was a reduction in hyperactivity as reported by carers. Teachers noted improvement in some problem areas but not in others. The percentage of children in the borderline or clinical range for total difficulties decreased according to all respondent types. The area of difficulty where most improvement was noted across respondent types was hyperactivity, with improved prosocial behaviours showing the least change.

The SDQ also provided an avenue for the respondents to comment directly on whether they believed the child’s problems had improved and whether the service had been helpful. In order of frequency the majority of carers, young people, teachers and parents noted improvements in the child’s difficulties. Similarly, in order of frequency the majority of carers, parents, teachers and young people noted the helpfulness of the Take Two program.

Outcomes – Trauma
Twenty-four children completed two or more TSCCs that enabled analysis of change over time in trauma-related symptoms. Trends towards improvement were found in all scales, with significant changes in the reduction of the mean scores of specific trauma symptoms and anxiety. There was also a consistent pattern of reduction in the percentage of children in the clinical range of all scales. This reduction was significant for depression.

Outcomes – Stakeholder feedback
The voice of the child and his or her family is heard through a number of avenues in this evaluation. Some outcome measures rely on the self-report of the child and reports of members of their immediate family and social systems (e.g., school). Feedback also came from the stakeholder survey in which there were direct reports from 28 children and 246 other stakeholders, such as parents, carers, teachers and other workers, such as from Child Protection and Community Service Organisations.

The level of satisfaction regarding their experience of Take Two was positive for the large majority of all stakeholder groups, although this was true for a smaller proportion of parents, albeit still a majority. In terms of whether improvements had occurred as a result of Take Two involvement, most stakeholder groups agreed, although generally fewer than those reporting satisfaction. The largest group to agree that positive change had occurred were the young people themselves, where over two thirds agreed. These reports demonstrate a high level of satisfaction among the children and their networks for the Take Two service. They saw positive improvements resulting from Take Two involvement.

Outcomes – Clinicians’ feedback
Clinicians rated overall progress as good or excellent for over half the children and as fair for a third. Children aged between three and nine years were significantly more likely to show good overall progress than older and younger age groups.

Overall, clinicians reported little improvement in parents’ capacity to understand or meet the emotional needs of their children. Over a third of the parents showed improved understanding of their children’s needs and less than a third showed improved capacity to meet these needs. This may reflect the chronicity of problems experienced by many of these parents and that, in some situations, improved understanding was not yet translated into action.

Improvements were noted by Take Two clinicians in the schools’ capacities to understand and respond to the children’s needs.

Summary
A description of the findings as detailed in this report is listed in Appendix One.

The second stage of the three-phase evaluation of Take Two has highlighted the following:

1. Effective interventions
   - The majority of the Take Two client group have experienced severe abuse and neglect, warranting great care and deliberation in the approach to intervention.
   - Take Two clinicians have demonstrated remarkable ability to engage these often difficult to reach and vulnerable children in interventions.
   - The consequences of abuse, trauma and disrupted attachment require complex forms of intervention including collaborative and sometimes complementary involvement with other service providers.
   - Developing effective interventions with the children, including when their safety is not yet ensured, is a major issue.
   - The important role of providing consultations to other services in their work with traumatised children.

2. Culturally appropriate approach
   - Take Two is continuing to build a culturally appropriate approach to work with Aboriginal children and their families.

3. Improved outcomes
   - The early trends from the analysis of the outcome measures suggest that there are positive changes for the children in terms of their emotional and behavioural symptoms; trauma-specific symptoms and their relationships with others.

4. Future action
   - A comprehensive database that is being built as part of the evaluation will provide opportunity for further analyses of the characteristics of the children and their families, the consequences of abuse and neglect; and an understanding of ‘what works for whom’ in relation to therapeutic intervention.
Chapter 1: Introduction

The evaluation of the first two years of operation of the Take Two program builds on the formative evaluation conducted in the first year (Frederico, Jackson, & Black, 2005). The first report presented the implementation of the program and provided a detailed description of the client group and their context. This second report provides a more detailed description of both the client group and the continuing development of Take Two over 2004 and 2005. It begins the analysis of the baseline data for outcome measures followed by initial outcome results, and provides stakeholder feedback regarding the satisfaction and efficacy of the program. In this middle phase of a three-year evaluation cycle there is a confluence of data and methodologies explored and expanded in this report.

In terms of program development, the second year of operation of Take Two consolidated the team structure for service delivery and strengthened the Aboriginal team. There was further development of the Practice Framework and implementation of key concepts such as the Help Desk function and care team approach.

As inferred in the title of this report, Malcolm’s counsel in Shakespeare’s Macbeth reflects Take Two’s task of helping children and those who care for and about them to “Give sorrow words: the grief that does not speak.” This second evaluation report aims to give words to the sorrow and trauma experienced by many children involved with Take Two, both through their own words and in the words of others, to support healing.

In addition to ongoing data collection regarding the nature of the Take Two client group, self-report outcome measures provide first-hand accounts of the children’s perception of themselves in terms of emotional and behavioural presentation and to some extent their perception of others in their lives. These measures include the Strengths and Difficulties Questionnaire (SDQ), the Trauma Symptom Checklist for Children (TSCC) and the Social Network Map. Client surveys have provided insight of the children’s view of their experience of Take Two and whether or not they see it as of assistance to them.

The SDQ also provided opportunities for feedback about the child’s emotional and behavioural presentation from parents, carers and teachers. This second evaluation report includes results from feedback surveys by parents, carers, teachers, Child Protection workers, Community Service Organisation workers and others. Specific surveys were designed to address the Take Two role in the Secure Welfare Service and these were supplemented by a focus group involving Secure Welfare Service staff and management.

Although it is early days for reporting on outcome measures, a significant amount of baseline data has been collected regarding the clients of Take Two. Some preliminary outcome data has also been collated from the documentation of a small but growing number of review and closures.

This report includes the Take Two clinicians’ perspectives on the children’s experience and the role of Take Two in their ongoing process of recovery. In addition, there was an opportunity in 2005 to undertake a cross-sectional analysis of a large sample of Take Two clients’ speech and language development. This has provided a heightened awareness of the connection between certain developmental issues and the children’s many experiences of trauma and deprivation.

A timely influence on the evaluation was the award of the Creswick Fellowship in 2004 to the Take Two Research Manager. This supported her visits to and engagement with key researchers and practitioners in the USA and Canada in 2005. Some of the findings from this Fellowship are reflected in this report.

1.1 Description of Take Two and its context

Take Two is auspiced by a consortium which is led by Berry Street Victoria (BSV) in partnership with Austin Child and Adolescent Mental Health Service (CAMHS), School of Social Work and Social Policy, La Trobe University and Mindful (Centre for Training and Research in Developmental Health). These partners bring together extensive experience in mental health and child welfare, as well as in providing direct service and academia.

Take Two is funded by the Victorian Department of Human Services (DHS) to provide a therapeutic service for Child Protection clients who have suffered severe abuse and neglect and who demonstrate or are at risk of demonstrating emotional and behavioural difficulties. Child Protection provides the gateway by which referrals are made to Take Two. This process entails case managers from either Child Protection or Community Service Organisations identifying possible referrals and sending the requisite information through the regional Child Protection Manager or his or her delegate. Child Protection, in partnership with Take Two, then determines the appropriateness and priority of the referrals. This reinforces the imperative of a collaborative relationship between Child Protection and Take Two.

1 The term ‘Aboriginal’ refers to both Aboriginal and Torres Strait Islander people unless otherwise specified.

2 The terms ‘child’ or ‘children’ will be used henceforth to include infants, children and young people, unless otherwise specified.

Take Two was established with two key objectives; namely, to provide a high quality clinical program and to contribute to service system improvement. There was a clear expectation that Take Two would be run as a statewide program, but with locally provided services. In order to achieve these expectations, a program structure was developed that consisted of a central management and administration team led by the Director; nine regional clinical teams located throughout the state (as shown in Figure 1); a statewide Aboriginal team; a senior clinical position located within the DHS-Secure Welfare Service; a training team, located at Mindful; and a research team, located at La Trobe University.

Figure 1. A map of Take Two clinical locations in 2005

This structure also illustrates the role of the partners in Take Two. All the staff employed by Take Two, except for a couple of positions within the research team, are employees of Berry Street Victoria. Austin CAMHS provides the clinical expertise through such functions as chairing the Clinical and Program Advisory Group and providing access to psychiatric consultation. Mindful, which is auspiced by the Victorian DHS-Mental Health Branch, the University of Melbourne and Monash University, has the role of supporting and supervising the internal and external training functions undertaken by Take Two. La Trobe University’s role is to design, support and supervise the Take Two research and evaluation functions. Figure 2 illustrates the Take Two partnership and team functions.
In addition to working closely with Child Protection, Take Two's ability to achieve positive changes for children and their families is predicated on effective working relationships with other services. An example of this working relationship is the Take Two role within the Secure Welfare Service. The Secure Welfare Service is a DHS service that provides a brief contained setting for young people whose behaviour places them at risk of serious harm. Take Two has a Senior Clinician located within the Secure Welfare Service to provide assessments, make recommendations and provide consultation and education to staff regarding the specific needs of many of the young people. Another example of the importance of working effectively with other services has been the work undertaken by the Aboriginal team with Indigenous services, such as VACCA. Other key examples of the importance of working with other services has been the ongoing work with many Community Service Organisations regarding children who are placed in their care and with schools regarding the needs of their students.

These and other examples are illustrations of the part that Take Two plays in an elaborate service system that endeavours to work in the best interests of these most vulnerable children. This evaluation report therefore aims to not only portray the work of Take Two, but to do so in the context of this service system.

1.2 Structure of the report

Following this Introduction, Chapter 2 provides an overview of the evaluation design and methodology.

Chapter 3 describes the continuing implementation of Take Two and identifies changes and further development of the program.

In Chapter 4 the report presents the characteristics of the children and their families who form the client group of Take Two over the first two years of operation.

Chapter 5 contains an exploration of the interventions for the children and their families undertaken by Take Two clinicians and describes other services involved.

Chapter 6 provides an analysis of a sample of 29 case studies and presents the more detailed stories of nine children including a description of their experience with Take Two. The chapter provides examples of outcomes which then leads to the next five chapters that provide more detailed information regarding outcome measures and preliminary results.

Chapter 7 provides analysis of the children’s description of their social network through the use of Social Network Maps and some initial findings in relation to outcomes.

Chapter 8 continues this theme by providing analysis of the SDQ results, both at baseline and in identifying change over time.

This is followed by Chapter 9 which similarly reports on the findings from the TSCC.

Chapter 10 provides analysis regarding stakeholder feedback in relation to satisfaction with the program and opinions about outcomes for the children.

Chapter 11 reports on information provided by Take Two clinicians regarding their perception of outcomes.

Chapter 12 concludes the report with the key findings and subsequent implications from this second evaluation. The findings from this evaluation are then listed in Appendix One.
Chapter 2: Evaluation design and methodology

2.1 Overview

These are difficult times for children, and for adults who care for and about children. Perhaps it was ever so, but it is now recognised just how complex a challenge it is to ensure that all children receive the recognition and praise, the love and security, and the opportunities for new experiences and responsibilities they need if they are to thrive. Developing an adequate and useful understanding of that complexity requires research. (Iwaniec & Pinkerton, 1998, p. xi)

This chapter presents the evaluation framework and its application to the Take Two program. Following discussion of the evaluation and the outcomes framework, each data collection approach is discussed in relation to: the rationale for selection of the measure; the respective strengths and limitations; and their implementation in the program. The outcome measures include the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1999), the Trauma Symptom Checklist for Children (TSCC; Briere, 1996) and the Social Network Map (Tracy & Whittaker, 1990).

The evaluation design carried over from the previous year includes analysis of referral documentation, client activity records, staff journals, program documentation and use of case studies (see previous report, Frederico, Jackson, & Black, 2005 for more detail on the first year’s methodology). New data collection methods introduced for this second evaluation include: outcome measures; stakeholder surveys; a focus group; analysis of a speech and language draft screening tool; and surveys of Take Two clinicians.

The evaluation framework as described in the first report continues to inform the ongoing evaluation strategy and methodology. No outcome measures, even in combination, can completely portray children’s past or present experiences or their relationships. They are indicative, but not proof, of aspects of the children’s lives, either before or after intervention. Trauma, in particular, is very difficult to adequately describe (Herman, 1992/1997). The framework places the outcome measures, in addition to the detailed description of the client group and types of interventions, stakeholder feedback and other methodologies, in a comprehensive context that helps to avoid over-simplification or over-reliance on any one or two approaches.

As seen in Figure 3, the centre of the framework is an attempt to achieve a holistic and in-depth understanding of the internal and external world of the child. This central focus demonstrates the importance of a developmental and ecological perspective in understanding children. As such, the evaluation strategy includes outcome measures and other methodologies which reflect aspects of the children’s internal world and their relationships. These include measures that are completed by the children and those that are completed by significant others in the children’s lives, such as their parents, carers and teachers.

The surrounding and interactive elements in this framework also continue to inform the evaluation. For example, the conceptual foundation of Take Two is strongly influenced by trauma and attachment theories, and one of the outcome measures is primarily trauma-focused, as are aspects of the referral documentation.
A core requirement of the outcome measures is that they inform clinical assessments as outlined in the second quadrant regarding multiple levels of assessment and intervention. The outcome measures form part of the assessment process which is comprehensive and developmentally focused. Some of the measures reflect the children's perception of their network and others reflect the network's perception of the children.

Every element of the evaluation framework includes the need for assessments, interventions and the evaluation itself to be culturally sensitive. This evaluation reports on the work undertaken by the Take Two Aboriginal team to conduct and facilitate culturally sensitive practice. The research team in partnership with the Aboriginal team within Take Two and VACCA have begun a process of exploring and possibly adapting culturally appropriate measures for Aboriginal children. As part of this endeavour, the partnership was successful in obtaining a research grant from the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) to employ an Aboriginal Research Officer. The Research Officer was recruited in 2006 and will continue in the project throughout 2007. In the meantime, the current suite of measures used in Take Two is applied with Aboriginal children when considered appropriate by clinicians.

The third quadrant reflects the action research and action learning components inherent within Take Two. The evaluation framework constitutes a major part of this feedback loop enabling research and practice to inform each other.

Action research is a process of systematically collecting research data about an ongoing system. Its purpose is to develop or discover aspects of the system's operation which can lead to improvement and change. The process involves understanding the system, defining solutions or discoveries, applying and modifying these solutions, and assessing the results of the actions. (Cunningham, 1993, p. 9)

The fourth quadrant signifies the value of describing the implementation of a new program such as Take Two. It provides useful contextual information in which to
understand other aspects of the evaluation as well as providing insight into the development of such a program. Austin, Cox, Gottlieb, Hawkins, Kruzich, and Rauch (1982) draw attention to the merit of describing the history of program development as part of program evaluation. It is important to describe the onset and development of a statewide program that is run centrally and provides services locally. This includes understanding the rural and metropolitan contexts and the significance of the varied inter-service relationships.

2.2 Outcomes framework

The aims of Take Two are to: establish safety; strengthen attachment; assist recovery from trauma; and enhance child development, health and wellbeing. As such these are expected clinical outcomes for individual cases. A broader conceptual framework is the Toronto Child Welfare Outcome Indicator Matrix (Trocme, Fallon, Nutter, MacLaurin, & Thompson, 1999; Trocme, Nutter, MacLaurin, & Fallon, 1999). This framework has four domains: safety, wellbeing, permanence and family and community support. The Toronto framework is consistent with the Looking after Children framework that was adopted in Victoria by DHS. Take Two adapted the Toronto framework to better fit with a therapeutic role and the Australian context and added goal attainment as a fifth domain (as shown in Table 1).

In further developing the outcomes framework for Take Two it was necessary to consider how to measure the achievement, or otherwise, of the intended outcomes. This degree and type of outcome measurement is a rapidly developing concept within the mental health field, but is a relatively new concept within child welfare. As Take Two bridges both these fields it was considered that the outcome measures should follow accordingly. The research team and the Take Two Outcomes Reference Group explored a range of possible measures including those used by the Australian Mental Health Outcomes and Classification Network (AMHOCN). It has been beneficial to learn from the substantial work undertaken by the AMHOCN regarding outcome measurement that is utilised in child and adult mental health services throughout Australia.

A key factor in determining which measures to use was the requirement that they have clinical utility as well as being valid and applicable measures for this client group. After a review of the literature and consultation with DHS and the Take Two Research Advisory Committee (T2RAC), the initial suite of outcome measures decided upon for Take Two client-related work were:

- Strengths and Difficulties Questionnaire (SDQ) by Robert Goodman (1999);
- Trauma Symptom Checklist for Children (TSCC) by John Briere (1996); and
- Social Network Map by Elizabeth Tracy and James Whittaker (1990).

It was also agreed that stakeholder surveys would be used to ascertain client, family, carers, teachers, case managers and others feedback regarding outcomes and their experience of the service provided. This suite of measures provides a combination of self-report and other-report measures; standardised psychometric measures (such as the SDQ and TSCC); and more qualitative measures (such as the Social Network Map and the stakeholder surveys).

It is envisaged that a goal attainment scaling process will be implemented once the computerised client information system is in place within Take Two. There remain other gaps in measures, such as those appropriate for infants, for Aboriginal children and measures regarding attachment. These additional measures are in the process of being selected or developed but were not available for this report. Similarly, there are not yet measures in place to assess Take Two’s role in contributing to the service system. It is also recognised that none of the current measures provide an opportunity for Take Two clinicians to feedback regarding the outcome of the intervention, though this will be part of the goal attainment scaling process. As such for this evaluation, a clinician survey was added to the data collection process.

Table 1 on page 8 shows the Take Two version of the Toronto framework by Trocme and colleagues (Trocme, Fallon, et al., 1999; Trocme, Nutter, et al., 1999) with descriptions of possible outcomes and how they are measured within Take Two.
2.2.1 Strengths and Difficulties Questionnaire (SDQ)

The SDQ was developed in the United Kingdom by Professor Robert Goodman (1999) and is used in the AMHOCN for Child and Adolescent Mental Health Services (CAMHS) programs. It was considered important for Take Two to use at least one of the CAMHS measures to enable comparison. The SDQ is based on the scales developed by Michael Rutter in the 1970s, but with additional standardisation and inclusion of strength-based items. The SDQ is less than a quarter of the length of the Child Behaviour Checklist (CBCL; Achenbach, 1991) which is considered the strongest validated checklist measure in research on children (Fonagy, Target, Cottrell, Phillips, & Kurtz, 2002). Studies have reported that the SDQ has comparable reliability and validity with the CBCL (Hawes & Dadds, 2004; Mellor, 2005).

There are separate versions of the SDQ depending on the age of the child and who is completing the measure. One version is designed to be completed for four- to ten-year-olds, with a form for parents and carers and another for teachers. There is also a version for young people aged 11 to 17 years, in addition to the parent/carer and the teacher form for this age group.

The first 25 items measure emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behaviour. From each of these categories a score is calculated and the first four of these scales are combined to give a total difficulties score (possible score ranges from 0 to 40). The scales and total difficulties score have three categories, normal, borderline and abnormal (of clinical concern). Approximately ten percent of the standard population fall into the borderline range and ten percent into the abnormal or clinical range (Mellor, 2005).

The remainder of the SDQ form explores the effect that the children's difficulties have on them, their parents/carers or teachers and from which an overall impact score is calculated. There is a follow-up version of the SDQ used at review and closure, which asks additional questions about whether the respondents consider the service had any benefit for the child. For the SDQ to be valid at least 20 of the first 25 items must be answered. Similarly, if more than one question is left unanswered in a particular scale, a score is not calculated for that scale.

Although the SDQ is not an alternative to diagnosis by assessment and formulation, it is a useful instrument in predicting mental health problems (Mathai, Anderson, & Bourne, 2002, 2003, 2004; Hayes, 2007). Furthermore, it has been used to evaluate pre- and post-treatment outcomes (Mathai, Anderson, & Bourne, 2003; Mellor, 2005). One of the advantages of the SDQ is that young people, parents, teachers and carers can each complete the simple questionnaire. This provides the opportunity to triangulate responses from different sources in relation to the client. The concept of using multiple sources to collect information about the child is endorsed in much of the literature (Nader, 1997; Fonagy, et al., 2002). It is envisaged that as the data set increases, this type of analysis will be possible with the Take Two client group.

### Table 1

<table>
<thead>
<tr>
<th>Domains</th>
<th>Child outcome descriptions</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Safety</td>
<td>• Reduction of harm related to child’s behaviour.</td>
<td>• SDQ</td>
</tr>
<tr>
<td></td>
<td>• Promotion of child’s safety.</td>
<td>• TSCC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stakeholder surveys</td>
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<tr>
<td></td>
<td></td>
<td>• Clinician survey</td>
</tr>
<tr>
<td>Child Wellbeing</td>
<td>• Recovering from trauma.</td>
<td>• TSCC</td>
</tr>
<tr>
<td></td>
<td>• Reduction of behavioural and/or emotional symptoms.</td>
<td>• TSCYC</td>
</tr>
<tr>
<td></td>
<td>• Improved cognitive and/or language development.</td>
<td>• SDQ</td>
</tr>
<tr>
<td></td>
<td>• Improved school attendance and/or performance.</td>
<td>• Stakeholder surveys</td>
</tr>
<tr>
<td></td>
<td>• Enhanced emotional, behavioural, social and/or physical wellbeing and/or functioning.</td>
<td>• Clinician survey</td>
</tr>
<tr>
<td>Stability/ Security/ Connectedness</td>
<td>• Strengthening attachments and/or forming quality relationships.</td>
<td>• Social Network Map</td>
</tr>
<tr>
<td></td>
<td>• Strengthening child’s identity, sense of belonging and connectedness.</td>
<td>• Stakeholder surveys</td>
</tr>
<tr>
<td></td>
<td>• Contributing to an appropriate, stable and secure placement for the child</td>
<td>• Clinician surveys</td>
</tr>
<tr>
<td>Family &amp; Community Support</td>
<td>• Strengthening quantity and quality of informal and/or formal social networks.</td>
<td>• Social Network Map</td>
</tr>
<tr>
<td></td>
<td>• Strengthening parents’, other family members’ and/or carers’ capacity to meet child’s emotional and other needs.</td>
<td>• Stakeholder surveys</td>
</tr>
<tr>
<td></td>
<td>• The goals as specified by the child and/or significant others have been achieved.</td>
<td>• Clinician surveys</td>
</tr>
<tr>
<td>Specific Goal Attainment</td>
<td>• The goals as specified by the Take Two clinician have been achieved.</td>
<td>Measures as specified in the goal attainment scale process</td>
</tr>
</tbody>
</table>

Note. The TSCYC is the Trauma Symptom Checklist for Young Children (Briere, 2005) and was not implemented until late 2005, so is not discussed in detail in this report.
The SDQ has been validated and used in large studies in other countries, such as the study by Meltzer, Gatward, Goodman, and Ford on the mental health of children and adolescents in Great Britain (2000). Studies within Australia include those by Hawes & Dadds (2004) and Mellor (2005). The SDQ was used in the Royal Children’s Hospital’s Stargate evaluation (Milburn, 2004). The parent-report measure of the SDQ has been used in a large-scale evaluation of trauma treatment for children exposed to the terrorist attack at the World Trade Center in New York (Hoagwood & Rodriguez, 2005). It has recently been adapted for use in the Western Australian Aboriginal Child Health Survey (Blair, Zubrick, & Cox, 2005; Zubrick, Lawrence, de Maio, & Biddle, 2006).

A major advantage of the SDQ is that in addition to assessing behavioural and emotional symptoms, it assesses the social impact and family burden of these symptoms (Mathai, Anderson, & Bourne, 2004).

Since the SDQ is brief, valid, captures behaviours from multi-informants, and has an impact scale which measures burden and social impairment, it is considered a useful screening tool for children presenting with mental health issues. (Mathai, Anderson, & Bourne, 2004, p. 643)

Other benefits of the SDQ are that it involves no cost, is readily available and has been modified for the Australian population in agreement with Professor Goodman. Adaptations for Aboriginal children undertaken in the Western Australia study (Blair, Zubrick, & Cox, 2005; Zubrick, et al., 2006) are being explored in partnership with VACCA as part of the AIATSIS project previously mentioned.

In 2005 the Take Two Research Manager participated in a DHS-convened working group to consider methods to assess the levels of support required for the different levels of complex needs of children in home-based care. As part of the process, the SDQ was piloted in two regions to ascertain its applicability as a tool for case managers. Members of the Take Two research team provided training on the use, scoring and interpretation of the SDQ. Subsequently the DHS-Office for Children has used the SDQ in relation to children in foster care. The survey pilot and results contributed to the Family and Placement Services Sector Development Plan: Agreed Funding Model Project. A similar study by DHS regarding children in residential care is currently underway. As these studies primarily involved case managers as respondents, the data could not be compared to SDQs completed by other types of respondents, such as in the Take Two evaluation.

As with all measures there are limitations to the SDQ. For example, the SDQ does not include items relating to substance abuse, self-harming or suicidality and is a reasonably broad measure. It has high face validity, indicating that the meaning behind each item is readily evident. This can potentially lead to purposeful responses to emphasise a specific presentation, for example to show that a child is difficult to manage. Another question yet to be fully determined for both the SDQ and the other measures is whether or not they are sufficiently sensitive to demonstrate change over time, especially given the broad nature of the tool, the small number of questions and its use with children who are highly traumatised. In other words, children may progress in terms of certain symptoms but still register as being in the clinical or borderline range. Studies such as this evaluation will hopefully contribute to the discussion around these and related questions.

2.2.2 Trauma Symptom Checklist for Children (TSCC)

As stated in the first evaluation report (Frederico, Jackson, & Black, 2005), many of the Take Two client population and their families have experienced multiple traumas over their lifetime. Trauma theory is a foundation of the Take Two Practice Framework for both describing the children’s experiences and explaining many of their behavioural and emotional symptoms. Nonetheless, measuring traumatisation itself is a complex task (Herman, 1992/1997). For example, according to Hawkins and Radcliffe (2005), there is little known about how multiple traumas impact on symptom expression in children. Briere and Elliott (1997) argue that trauma symptoms should be specifically assessed in addition to a general assessment regarding behavioural and emotional symptoms.

Many available measures relating to trauma focus on describing particular traumatic events or assume a traumatic event has recently occurred. Briere (1996) developed the TSCC to measure trauma-related symptoms for children aged between 8 and 16 years. It is most commonly utilised in relation to sexual abuse, although it has also been used with other types of abuse and trauma (Ohan, Myers, & Collett, 2002; Nader, 1997). The TSCC is based on an adult measure also designed by Briere (Trauma Symptom Inventory).

The TSCC is a self-report questionnaire, which takes approximately 15 to 20 minutes to complete. It consists of 54 items relating to thoughts, feelings and behaviours and the children are asked to indicate frequency on a four-point scale.

The [TSCC] instrument has been used to assess the level of symptoms for children exposed to child abuse and other violence (Singer, Anglen, Song, & Lunghofer, 1995) and to assess the outcome of therapy for sexually abused children (Lanktree & Briere, 1995; Cohen & Mannarino, 1992). (Nader, 1997, p. 335)

The TSCC was not designed to provide a total score function (J. Briere, personal communication, November 2006); however, some studies have adapted the measure to include such a total score (e.g. Wekerle, Wolfe, Hawkins, Pittman, Glickman, & Lovald, 2001). The TSCC has predictive value in normal and clinical samples. It has been normed separately for males and females and for two different age groups (8-12 years; 13-16 years). It consists of two validity scales and six clinical scales.

The two validity scales indicate if the respondent is under- or over-reporting symptoms. The under-response validity scale indicates if the TSCC is invalid due to under-endorsement of items. This is indicative of denial or minimisation of difficulties. Briere (1996, p. 11) reports that children responding in this manner are ‘likely to be especially defensive or avoidant, oppositional regarding test-taking, or, for some other reason unwilling to endorse commonly endorsed items’. The hyper-response validity scale indicates if the TSCC is invalid due to over-endorsement of items. According to Briere (1996, p. 12) hyper-response typically reflects ‘a generalized overresponse style, a desire to appear especially distressed or dysfunctional, or a “cry for help”’. Invalid measures due to either under-response or over-response do not imply an absence or presence of abuse or other trauma, but meaningful interpretation of the six clinical scales is not statistically or clinically possible.
The clinical scales are anxiety; depression; anger; posttraumatic stress; dissociation; and sexual concerns. For example, the anxiety scale includes items designed to measure generalized anxiety, hyperarousal, worry and fears. The depression scale includes items regarding sadness, loneliness and impulses to harm oneself. The posttraumatic stress scale consists of items related to Posttraumatic Stress Disorder, such as re-experiencing the traumatic event, avoidance and hyperarousal (Crouch, Smith, Ezzell & Saunders, 1999). When children present with a score in the clinical range for one or more scales it indicates that the symptoms are greater than what would be statistically expected in the normal population. The assessment does not equate to diagnosis, although it can inform the formulation and clinical assessment (Ohan, Myers, & Collett, 2002).

The TSCC is frequently used for clinical assessment as well as for research purposes (Ethai, Gray, Kashdan, & Franklin, 2005). According to Nader (1997) the TSCC scales correlate significantly with the CBCL (Achenbach, 1991). It is used in Australia, for example in the Royal Children’s Hospital’s Stargate program (Milburn, 2004). It is also used in the United States in the National Traumatic Stress Network, including sexual assault treatment services. Nader (1997) concludes that the TSCC is an easy and cost-effective method of interviewing children regarding symptoms related to traumatization. Another advantage of the TSCC is that extensive training is not required due to its simplicity and the provision of a detailed manual (Nader, 1997). According to Strand, Sarmiento, and Pasquale (2005) the TSCC was found to be:

An exceptionally well-evaluated measure, [the TSCC] is useful for rapid assessment. It can be administered quickly and yields statistically reliable and valid information for a variety of domains. (p. 70)

However, some limitations have been identified. According to Greenwald and Rubin (1999), the TSCC is too lengthy and does not address some important trauma symptoms, such as somatic complaints and being pessimistic about the future. Another limitation is that the TSCC is a solely self-report measure which means that results are unable to be compared with other respondents, such as parents or carers (Hawkins & Radcliffe, 2005). The reliance on the young person’s response to a structured questionnaire means there is no opportunity to triangulate other responses. The introduction in Take Two of the Trauma Symptom Checklist for Young Children (TSCYC: Briere, 2005) in late 2005 provides opportunity to gather parents and carers’ perspectives, but this was not available for this report. Children who are highly traumatised or have suffered developmental harms may not be in a position to complete such a questionnaire or may under-report their symptoms (Briere & Elliott, 1997). A further limitation is that the studies used to compare results with the general population have largely been based in the United States, so the TSCC has not yet been normed to the Australian population. Unlike the SDQ, the TSCC is not free and requires a budget allocation to establish and maintain a supply of measures.

### 2.2.3 The Social Network Map

The Social Network Map (Tracy & Whittaker, 1990) is not a standardised, psychometric instrument, but a systematic, semi-structured approach to obtaining information about the person’s perception of their social network. Take Two is using this tool to ascertain the child's perspective of their informal and formal social networks.

### The importance of social networks

Studies undertaken from a range of perspectives have noted the importance of social networks, yet it remains a relatively under-developed area of ongoing research and practice. Bronfenbrenner’s (1979) seminal work on the ecological perspective highlighted the role of social networks in the individual's life. Studies relating to trauma with a developmental psychopathology perspective have found an absence of social support to be harmful (van der Kolk, 1996; Robinson & Garber, 1995; Jackson & Warren, 2000). Social support systems or lack thereof are commonly described as mediating and as moderating factors in coping and recovery after a traumatic event (McFarlane, 1987; van der Kolk, 1996; Garbarino & Kostelný, 1996; Jackson & Warren, 2000). Studies of resilience in children also noted the importance of children’s informal social networks in fostering their potential, improving self-esteem, strengthening mental health and creating new social relationships beyond the out-of-home care system (Gilligan, 1999, 2000).

In keeping with a developmental perspective it is clear that children’s actual and perceived social networks are strongly influenced by both their age and development. According to Robinson and Garber’s (1995) review of the literature, elements of social networks that are influenced by these factors in childhood include:

- More elaborate sources of support and more effective use of social support networks among older children.
- More time spent with a wider variety of people in the networks of older children.
- More differentiated relationships occur more often for older children.
- The types of support provided often change as children grow older.
- Children’s perceptions of their parents and their ability to seek help from them, especially their fathers, change as they grow.
- Children’s perceptions of their siblings and their peers and their ability to seek help from them changes as they get older. This includes the concept of friendship itself, which change throughout development.
- Gender differences become more influential as children grow older.

The importance of parents in the lives of children is inarguable and well documented throughout the literature, such as in relation to attachment. Although less attention has been given to children’s relationships with others in the literature, there is evidence of their importance in the healthy development of children (Robinson & Garber, 1995; Gilligan, 2000; Rishel, Sales, & Koeske, 2005). Robinson and Garber (1995) noted that the relationships of younger children are primarily focused on their parents or caregivers and that broader social networks are largely directed by them, by arranging opportunities for social interaction and directly encouraging relationships.

Rishel and her colleagues’ study (2005) focused on the influence of non-parental adults on children’s behaviour, such as other family members, teachers and other adults in
the community. Those children who had greater frequency of contact and higher quality of contact with non-parental adults had fewer behavioural problems, especially when the adults were not related such as teachers, coaches and religious leaders. They hypothesised that for many children positive relationships with family members was the norm, and so was not a defining characteristic compared to positive interactions with non-family members. If this is the case, this could presumably be different with an at-risk client group as found in the Take Two program.

Research has shown that perceived support is more highly correlated with wellbeing than actual received support (Robinson & Garber, 1995).

... when a person encounters a relatively high number of stressful events and the level of distress due to those encounters rises, he or she actually seeks more support or is provided with such support by members of his or her network. However, perceiving the availability of a supportive network, whether or not the individual actually uses it, appears to be related to lower levels of distress. (Robinson & Garber, 1995, p. 163)

In studying social networks for at-risk families, Tracy (1990) posited a number of factors leading to impoverished or negative networks including: environmental factors related to living in socially impoverished neighbourhoods; personal factors such as poor social skills; and social stigma and social distance. There has been less focus on the study of the social networks of children.

The Social Network Map tool

The Social Network Map is a tool which enables the children to describe who is in their life and what they think of these relationships, in terms of: the level of closeness; type and amount of support; how often they see them; and how long they have known them. It is about the children’s perception of these relationships, not an objective assessment of them.

The Social Network Map was used in the Homebuilders program in the United States to gather the family's perspective of their social networks (Tracy & Whittaker, 1990) and other programs for at-risk families (Tracy, 1990). Shankar and Collyer (2002) used the Social Network Map to ascertain the role of the social network for people with mental illness involved in vocational rehabilitation programs. Harms and McDermott (2003) used the Social Network Map in their program evaluation of a Victorian trauma-informed program for youth homelessness. In their study, a small sample of young people showed the strong presence of family members through the Social Network Maps, although they did not perceive their family as providing a lot of support.

The first step in the Social Network Map entails the children to name the different people involved in their life across a number of domains (e.g. who is in their household, other family, school, other friends, neighbours, professionals and clubs or organisations). This information is placed in a circle, as seen in Figure 4. A more detailed set of questions then asks about the 'top' 15 people listed in the children's map and responses are placed in a social network grid, as seen in Figure 5. These questions relate to whether each person provides concrete support, emotional support and/or information or advice. The children are then asked if each person is ever critical of them and the direction of help. The children are asked to describe how close they are to each person, how frequently they see them and how long they have known them.

Figure 4. The social network circle (Part 1 of the Social Network Map)
The Social Network Map is described as helpful in the identification and assessment of stressors and resources within a person’s environment (Tracy, 1990). It requires and enables flexibility in administration by the clinician, whilst still requiring a consistent approach wherever possible. The Social Network Map is free and easy to access, as are articles which include useful descriptions regarding its administration (e.g. Tracy & Whittaker, 1990).

The tool takes longer to administer than the other measures used by Take Two and requires a greater degree of creativity in engaging the child to participate. Another limitation noted by Tracy and Whittaker (1990) is that social network data are not able to be subjected to the usual tests of reliability and objective verification of the social network data is difficult to determine. Furthermore, unlike the psychometric measures used in this evaluation, there are no normative data available to ascertain whether a Social Network Map constitutes a positive or a concerning presentation.

Clinical assessment is required to understand the meaning behind the child’s answers and what it reflects in terms of positive, negative or lack of change. Some Take Two staff have commented favourably on the flexibility and creativity required in the use of this measure and the richness of the qualitative information made available for use in assessment and for therapeutic sessions. However, the level of subjectivity and lack of standardisation, coupled with the length of time taken for its completion and greater complexity of the task for the child, has led other staff to question its usefulness and validity. As with other outcome measures, clinicians report that some children refused to do the Social Network Map - either passively or, at least in one instance, by tearing up the paper. For example, two children appeared to find questions regarding who is important in their life more distressing and troublesome than completing other measures that focused on their own behaviour. This illustrates both the importance of the children’s network and the complexity of exploring these issues with children.

It is hoped that this report of some of the preliminary qualitative results will assist in understanding the research and clinical utility of the Social Network Map. Associate Professor Elizabeth Tracy and Professor James Whittaker have been involved in discussions with Take Two regarding the application of this tool to children and in the Australian context. The Take Two research team is currently looking at some minor adaptations based on the findings from this evaluation to make it more child-friendly and culturally sensitive. This has also been informed by discussions with the Aboriginal team and the AIATSIS project regarding the use of measures with Aboriginal children.

A challenge of the use of Social Network Maps within Take Two has been the lack of ascertaining the consistency in administration of the tools. In Tracy’s (1990) study she used seven pairs of therapists to administer the Social Network Map with the same adult subject as an exercise to assess and train consistency of approach for clinicians. Tracy’s (E. Tracy, personal communication, October 2005) suggestion that role plays with staff improve consistency is being considered by the Take Two Outcomes Reference Group. All Take Two staff have been trained in the use of the measure and given the detailed scripts prepared by the developers of the tool to guide their approach (Tracy & Whittaker, 1990). However, further training would be advantageous to ensure increased utility of the tool and greater consistency of approach.

As the Social Network Map is not a standardised measure, there is no overt validity assessment. For the purposes of this report, internal validity was considered to exist if data were consistent with the clinician’s knowledge of who was in the family and broader network. The small number of Social Network Maps that were substantially incomplete were not included in the more detailed analysis.
2.2.4 Implementation and analysis of outcome measures

The measures described in this report relate to clients of Take Two over the 2004 and 2005 time period, including measures completed in 2006 about these children. The strategy within Take Two is to attempt all outcome measures that are age-appropriate for the child during the initial assessment phase and then every six months at time of review. A final assessment is done at closure.

There has been a gradual process to implement these measures from their introduction to Take Two in October 2004. A small number were piloted earlier, followed by an introduction period where they remained optional for some cases near or in closure phase. The use of these measures has been a core requirement for all eligible cases at the designated time periods since mid-2005. A number of reasons for a lack of regular collection of outcome measures were given including:

- Difficulties in implementing some outcome measures after children who were already clients of Take Two had previously been through the assessment phase within Take Two. This was also found by AMHOCN (2005) in the early stages of implementation within CAMHS.
- Variation across teams in compliance and implementation of the measures.
- Children and other respondents not willing to complete measures at certain stages, especially in an early phase of Take Two involvement.
- Inappropriate or not possible to ask children and other respondents at certain times, for example when the caregivers did not previously know the child or the parents’ whereabouts were unknown.
- The concept of outcome measures is relatively new to the field.
- The lack of a computerised client information system to alert Take Two staff that outcome measures are due.

As reported by AMHOCN (2005), the collection of outcome measures within CAMHS has increased since their inception in 2000. On a smaller scale, it is similarly expected that the collection of outcome measures will increase over time within Take Two. This will be facilitated by the clinicians and service system being more familiar with the measures and the introduction of the Take Two computerised client information system to support the process. Instituting routine outcome measurement in clinical programs has inevitable variations across sites, especially when including self-report measures.

As cautioned by Cicchetti and Toth (1995) and Fonagy and colleagues (2002), the developmental perspective indicates that symptoms cannot be considered as the only or major criteria of the effectiveness of therapeutic interventions.

2.2.5 The complexity of outcome measurement

In their review of mental health treatments for children and adolescents, Fonagy and colleagues (2002) comment on the complexity of outcome measurement and the need for caution in the interpretation of findings. They described different levels of outcome measurement including:

- Symptom reduction or change of diagnosis.
- Level of daily adaptation.
- Cognitive and emotional mechanisms that underpin symptomatology and adaptation (i.e. the logic of why this symptom is occurring and why this intervention is likely to help resolve or decrease the symptom).
- The transactional levels, such as the child’s immediate context.
- Level of service utilisation and satisfaction with services.

As cautioned by Cicchetti and Toth (1995) and Fonagy and colleagues (2002), the developmental perspective indicates that symptoms cannot be considered as the only or major criteria of the effectiveness of therapeutic interventions.

If psychiatric disorder is not just the end result of a series of interactions of biological, social, and psychological characteristics across time, but is itself part of a complex transactional causal chain, good outcome might sometimes be an increase rather than a decrease in symptomatology. (Fonagy, et al., 2002, p. 5)

An obvious limitation of outcome measures is that they only measure the constructs within them. For example, the TSCC cannot be used to diagnose Posttraumatic Stress Disorder as it does not include all criteria in the DSM-IV regarding that disorder. Most outcome measures focus on the individual’s symptoms and can therefore place an undue emphasis on the individual’s problems rather than family or system-related problems.

Fonagy and colleagues (2002) note that studies which compared structured interviews with checklists found both have reliability and validity; however, checklists took considerably less time to complete. Nonetheless, they argued for multiple measures from different informants. In general, they concluded that the greater the level of multiple measurement, the more robust the findings.

2.3 Stakeholder surveys

A core component of this second evaluation has been the development and piloting of a stakeholder survey tool. It was important to include a means to elicit direct client and stakeholders’ perceptions of the program and of whether changes had occurred.

Consumer surveys offer perhaps the least burdensome and costly means of assessing service quality and effectiveness, an important consideration given the limited resources available to most providers. However, what exactly quality means for consumers of child mental health services, and how consumer perceptions of services are related to treatment outcomes is still not well understood (Anderson, Rivera, & Kutash, 1998; Brannan, Sonnichsen, & Helfinger, 2000).
The process of developing the survey began with a review of the literature for similar surveys and consideration of its focus. The survey was also informed by the experience of the Take Two Research Manager's Creswick Fellowship in 2005. She had the opportunity to explore how other organisations elicited feedback from young people and other stakeholders and how they incorporated this feedback into their quality assurance processes.

Two surveys were particularly useful to the development of the stakeholder survey used in this evaluation. The first of these, used by Trillium Family Services, a child and adolescent mental health and out-of-home care service in Oregon, was a client survey designed by Brunk and Koch (1999). Brunk and Koch (1999) developed the Youth Services Survey (YSS) as part of a state indicator project for mental health services, adapted from other surveys such as the Family Satisfaction Questionnaire. There was a client and parent/caregiver survey version and it has been used in child and adolescent mental health programs in a number of states within the United States.

A useful aspect of the YSS survey is that it has one set of questions for satisfaction of the service and another set of questions for whether change has occurred among certain domains, such as school, home, family, friendships and general coping. This enabled analysis of respondents' general satisfaction and opinions of more specific outcomes.

The second survey that influenced the development of the Take Two stakeholder survey was the Client Satisfaction Questionnaire (CSQ-8; Larsen, Atkinson, Hargreaves, & Nguyen, 1979). This survey focused on the client's general satisfaction asking, "How would you rate the quality of service you received?"

Another survey which informed the physical design of the Take Two stakeholder survey was the Experience of Service Questionnaire (Commission for Health Improvement, 2002). Another informative survey was the Youth Satisfaction Questionnaire (YSQ; Stüntzner-Gibson, Koren, & DeChillo, 1995). The YSQ emphasised the need for brevity and positively framed questions when developing surveys for children aged nine years or older. For example, they noted that confusion is often experienced by children when asked to respond to negatively worded questions (i.e. that disagreeing with a negatively worded question means to respond to negatively worded questions (i.e. that confusion is often experienced by children when asked to respond to negatively worded questions when developing surveys for positively framed questions when developing surveys for children). The authors emphasised the importance of obtaining feedback directly from children and young people.

For the purposes of this evaluation, stakeholders include the children who are clients of Take Two, their parents, foster parents, kinship carers, residential care workers, teachers, Child Protection workers, Community Service Organisation workers, the Secure Welfare Service staff and others. As part of the development of this survey, consultation occurred with the BSV-Organisational Development team, the Take Two Outcomes Working Group and the Take Two Leadership Group and Senior Clinicians.

A draft design of a brief, simple survey was developed by the Take Two research team consisting of four sections. Firstly, there are some non-identifying demographic questions, such as age, gender and Aboriginal background. The second section included five fixed-choice questions about their experience of the Take Two service. In the third section, there are five or six fixed-choice questions (depending on the version) that elicit comments reflecting their views on the outcomes of the services received. The fourth section has two open-ended questions about what was helpful and what could improve the Take Two service. The fixed-choice questions require response to a series of statements by circling the most applicable option on a five-point Likert-type response scale ranging from Strongly Agree to Strongly Disagree. Following consultation with Professor Shane Thomas (La Trobe University), it was decided to ask questions about whether the program met core aspects of its intended design. This was consistent with the surveys developed by Brunk and Koch (1999), Commission for Health Improvement (2002) and Stüntzner-Gibson, Koren, & DeChillo (1995). The Take Two survey is brief with only one question per domain. Limiting the depth of measurement was balanced against the need for the survey to be short and self-explanatory.

A secondary objective was to pilot the survey tool itself before its implementation as a standard procedure of Take Two involvement. When an adapted survey was required at a later time regarding Take Two's role in Secure Welfare, changes were made after reviewing the results of the first version. These changes included the repositioning of the first question which frequently was unanswered in the first version; and adding Don't know and Not applicable as response options to the fixed-choice questions. These and other changes meant the analysis could not compare some questions across Secure Welfare and other Take Two teams, but due to the different nature of the role of Take Two in Secure Welfare that was considered acceptable.

Once the survey format was finalised, colour-coded versions were developed for clients, parents and carers and workers. A kit was sent to all Take Two offices that included copies of the surveys, instructions to Take Two workers about the process, letters for informed consent from parents and guardians, plain language information sheets to all stakeholders and pre-paid pre-addressed envelopes.

Guidelines to Take Two workers included advice that surveys were to be sent to children and young people, parents, carers and workers, for cases that were open for three months or longer. Although the expectation of the appropriate age of children to receive the survey was eight years or older, it was left to the clinicians' assessment and guardian's consent for what was appropriate.

Due to the short-term nature of admission to the Secure Welfare Service and the retrospective nature of this part of the methodology, surveys were not sent to the young
people who were clients of Take Two Secure Welfare. Surveys were sent to workers involved, such as case managers from Child Protection or Community Service Organisations. Other surveys were handed out to the Secure Welfare Service staff at the end of a focus group.

As this was a pilot survey, consideration of the limitations was useful to develop the survey and associated methodology. For example, combining culture, spirituality and religion in one item limited the ability to sufficiently analyse these responses. This question has since been changed to focus on culture. Another lesson arose from the large amount of missing data for the first question about overall satisfaction of the service. Subsequently this has been repositioned in the survey to improve awareness and comprehension of the question.

The Likert scale ranged from Strongly Agree to Strongly Disagree, with Undecided as the midpoint, informed by the YSS survey (Brunk and Koch, 1999). However, it became unclear whether this was understood as a midpoint between agree and disagree or whether it was seen as a 'don't know' option. If the latter was the case it no longer could be analysed as part of a continuous variable. For the purpose of this evaluation, undecided responses were excluded when calculating overall mean scores, such as the client change score for the stakeholders’ surveys. The wording of the midpoint response has subsequently changed for future surveys and a Don’t Know option has been added.

Although the YSS (Brunk & Koch, 1999) was developed with consumer participation, a similar process was not undertaken with the Take Two client group. It was envisaged that the initial survey would act as a pilot for the instrument and stakeholder feedback will be used to review and finalise the survey for ongoing use.

In the first survey all responses were anonymous. This limited analysis of results in terms of other client and service information. In addition the response rate could not be ascertained. This was also complicated due to varying practice by the Take Two teams in recording information regarding who received a survey.

### 2.4 Take Two clinician surveys

A key part of the evaluation strategy for this report was to survey Take Two clinicians’ perception of client outcome. They were also asked about client-related data that were not otherwise available. Clinicians were asked to rate client outcome or change in a number of areas with a focus on the children, their family, carers, school and the system supporting them.

The clinician survey was designed by the Take Two research team to include items based on the stakeholder surveys as described previously. There were also items added in response to specific DHS-Office for Children requests for data, such as questions regarding information of new abuse incidents since Take Two involvement and other services involvement with the child.

One question in the survey asked clinicians to indicate their assessment of the child on a grid informed by the development of the Take Two Practice Framework. This grid provided options about the child’s trauma presentation and the stability of placement (see Figure 6). Trauma presentation was described as active, complex or low. Active trauma equates to where children present with posttraumatic stress symptoms. Complex trauma is where the trauma has been a series of events and has usually occurred in early childhood and within a relationship. These children often present with affect dysregulation, disruption to relationship capacity and global delays. Complex trauma may co-occur with an active trauma presentation. Deprivation relates to the child’s experience of chronic neglect, which may or may not be traumatising, but is certainly harmful. Stability of placement in this context refers to the child’s access to a current nurturing caregiving relationship, not the number of previous placements.

Every Take Two clinician throughout the state, except for the Secure Welfare Senior Clinician, were asked to complete surveys on all cases open during 2005. The data were entered into an SPSS database for analysis. Responses of not applicable and not known were omitted from the overall analyses. For some of the questions, the clinician surveys included the same Likert scale as the stakeholder surveys, including undecided as a midpoint response. Similarly to the stakeholder surveys, undecided responses were omitted when calculating overall mean scores for this evaluation.

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**Figure 6. Take Two’s therapeutic grid as presented in the Take Two clinician survey**

| High trauma/deprivation (both active and/or complex trauma presentation) AND low stability of placement | Active trauma symptoms AND high stability of placement | Complex trauma presentation AND high stability of placement | Low trauma AND low stability of placement | Other |
2.5. Descriptive data of client group

As with the previous evaluation report (Frederico, Jackson, & Black, 2005), data were collected regarding the nature of the Take Two client group. The sources of data used in this evaluation are represented in Table 2.

<table>
<thead>
<tr>
<th>Type of data</th>
<th>Source of data</th>
<th>Time of data entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client demographic information, e.g. age, gender, Aboriginal identity, family structure</td>
<td>DHS-Client Profile Document; Confirmed with clinicians</td>
<td>Referral to Take Two</td>
</tr>
<tr>
<td>Client information regarding child protection and placement history and current legal status</td>
<td>DHS-Client Profile Document; Take Two Referral Guide</td>
<td>Referral to Take Two</td>
</tr>
<tr>
<td>Other services involved</td>
<td>DHS-Client Profile Document; Take Two Referral Guide</td>
<td>Referral to Take Two and at time of survey of Take Two clinicians in 2006</td>
</tr>
<tr>
<td>Child’s experience of abuse and neglect and the harmful consequences</td>
<td>DHS-Client Profile Document; Take Two Harm Consequences Assessment; Take Two Referral Guide; Take Two clinician survey</td>
<td>Referral to Take Two and at time of survey of Take Two clinicians in 2006</td>
</tr>
<tr>
<td>Additional information regarding Secure Welfare</td>
<td>Brief Intervention Reports written by Take Two. Data provided by the DHS-Secure Welfare Service</td>
<td>Time of writing report</td>
</tr>
<tr>
<td>Additional information regarding regional clients, e.g. placement at time of closure</td>
<td>Specific request of information to Senior Clinicians and Take Two clinician surveys</td>
<td>Retrospectively in 2006</td>
</tr>
<tr>
<td>Referral and closure dates of Take Two</td>
<td>Take Two allocation forms and Take Two closure forms. Take Two client activity records were used to help verify this data</td>
<td>Referral to Take Two and closure</td>
</tr>
<tr>
<td>Client-related activity including consultations by Take Two</td>
<td>Take Two client activity records</td>
<td>Throughout Take Two involvement</td>
</tr>
</tbody>
</table>

Considerable effort and time were given to validate the accuracy of the client data gathered from referral documents and specific data collection processes. Referral documents included the Take Two Harm Consequences Assessment and the Take Two Referral Guide. The DHS-Client Profile Document was also used as it is an auto-generated document by Child Protection that provides relevant information about the children's demographics and their involvement with the protection and care system. Data obtained from these documents, such as age, gender, court order, placement, protective and placement history, Aboriginal and Torres Strait Islander identity and services involved were manually entered into an SPSS database. This commonly required amending some information from the DHS-Client Profile Documents when they were not up-to-date or were used for a different purpose from that for which they were designed. For example, in 81 cases (32%) the child’s court order at the time of referral needed to be corrected from what had been recorded on the Client Profile Documents.

The placement history on the Client Profile Documents is usually a mixture of changes in placement, changes of address where there is no change in placement and some (but not all) admissions into the Secure Welfare Service. In these cases, the placement data were analysed to distinguish the number of moves a child experienced (including changes in placement and changes of address) from the number of placements. Secure Welfare Service admissions were not counted as a placement for the purposes of this and the first evaluation report.

2.6 Analysis of speech and language development

Arising from the findings in the first evaluation report (Frederico, Jackson, & Black, 2005), there was concern regarding the developmental and physical impacts of abuse and neglect on the wellbeing of children. Therefore, when the opportunity arose, discussions began in late 2004 with Associate Professor Anne Ozanne (School of Human Communication Sciences, Faculty of Health Sciences, La Trobe University), regarding assessment of children’s speech and language development. These discussions explored the utility of developing a screening tool to assist Take Two clinicians in determining when recommendations should be made for more detailed hearing, speech and language assessments. These discussions were in concert with the developmental perspective of Take Two and based on understanding the critical nature of communication for children in terms of their relationships with others, their sense of self-worth, their school functioning and their ability to effectively communicate in therapy.

As a result of these discussions, a speech and language screening tool was developed by Associate Professor Ozanne in partnership with the Take Two research team. As part of this process speech and language checklists were reviewed including Language for Learning: A Checklist for Language Difficulties, which is used by CAMHS (Language Learning Disability Special Interest Group, Vic, 2001). This was a useful tool but was considered not to cater for infants and preschool aged children.
The draft speech and language screening tool was piloted in 2005 and these data have been included in this evaluation report regarding the characteristics of the Take Two client group. The pilot included training of Take Two staff to identify speech and language disorders by Associate Professor Ozanne. The tool was distributed to Take Two clinical staff with a feedback questionnaire to elicit their experience in completing the tool.

Staff members were asked to complete the draft screening tool for a cross-section of open cases in early 2005. As a result of the pilot, the screening tool was adapted and a proposal submitted to DHS for an extension of the pilot to include hearing, speech and language assessments to inform interventions.

2.7 Staff journal analysis and case studies

As described in the first evaluation report (Frederico, Jackson, & Black, 2005), Take Two staff were asked to complete journals of their experiences and insights in relation to their work since the inception of Take Two. During 2005, journals changed from weekly to monthly or bi-monthly reporting and later to only when response to specific questions was needed. A small number of Take Two staff continued to provide general journals.

The journals asked about four regular issues followed by a new question each month or second month. The four standard issues were: (1) key events - what happened; (2) reflections, impressions, learnings and ideas; (3) challenges, barriers, hurdles; and (4) new planning and/or actions.

The additional questions were as follows:

- What strategies have you used or identified in working with the child’s informal and formal systems/networks? (March)
- What are your experiences in terms of the child’s social network’s - formal and informal? (April)
- What do you do to look after yourself in this role? (June)
- What are we doing as an organisation to make the best of our shared knowledge in a way that directly assists our capacity to intervene in the therapy session? What could we do differently? (July)
- What interventions/strategies have you tried in working with the service system, e.g. school, placement, Child Protection, other services? What works? (August/September)
- How would you describe the culture of your team and of Take Two in general? How does this culture facilitate your work? (October)

A final question before the journal methodology ceased in early 2006 asked each clinician to provide a case study that included a description of the client and his or her experiences, the interventions Take Two undertook with the child, the child’s social network and broader system and any known outcomes. This provided the basis for Chapter 6 regarding case studies.

2.8 The Secure Welfare Service focus group

In June 2006 a focus group was conducted with staff of the Secure Welfare Service to obtain feedback of the Take Two Secure Welfare role and to explore Take Two’s impact on the service. Ten staff members participated in the focus group. The Secure Welfare Service staff were asked to reflect on their experiences of Take Two as it interfaced with their service. Although this was predominantly the Take Two Secure Welfare position, it also included the roles of the Aboriginal team and the regional teams when they had clients admitted to the Secure Welfare Service. In addition to the focus group, participants were asked to complete a brief questionnaire indicating how often they had contact with the different aspects of the Take Two service.

The questions addressed as part of the focus group included: What were your expectations of the role of Take Two before Take Two began? How does the Take Two service impact on the lives of Secure Welfare clients? How do you see the Take Two service fitting within the broader Secure Welfare Service? What would improve the Take Two role at the Secure Welfare Service?

2.9 Statistical analysis

Quantitative data analysis was conducted using the Statistical Package for Social Sciences (SPSS Version 14). NVivo 7 is software which helps to access, manage and analyse qualitative data. This was used to assist in the qualitative analysis, such as the open-ended questions in the stakeholder surveys. The total population of the Take Two client group was included in the analysis when data were available. Baseline and outcomes data were available for a sample of the children over the age of three years. Clinician survey data were available for all cases open in 2005 excluding Secure Welfare.

Data were tested for statistically significant differences using chi-square (X²) analysis for categorical data and t-tests and Analysis of Variance (ANOVAs) for continuous variables. Pearson’s r correlations were conducted to examine associations between variables.

2.9.1 Missing data

For the majority of the analyses presented in this report missing data ranged from zero to ten percent. Most missing data were because referral documents were not received or the documents were incomplete. Other reasons for missing data included information not being known by the clinician, such as in the clinician surveys and in the client activity records regarding consultations.

If the amount of missing data was ten percent or more, it is noted in the report. The data in some situations were still included due to the importance of the information, but the results are considered to be indicative only.

In other instances data were collected but not reported because there was a large amount of missing data and interpretation of these data may have been misleading.

2.10 Limitations

As in all evaluations, there were a number of limitations. Some of these limitations, which relate to outcome measures, have been identified earlier in this chapter. In addition two other factors limit the data collected. In the first evaluation report Take Two clinicians were interviewed to gather data that was not otherwise available. This procedure was not followed in the second evaluation due to time and personnel constraints.

Although the clinician survey captured some of this data it was not as extensive as the interviews. As such, some data available in the first report were not available for this report. In particular, description of the child’s family’s experience of trauma and the Take Two clinician’s goals of intervention were not collected.

Delays in implementation of the Take Two computerised client information system have led to a number of limitations or challenges in the evaluation. These include the extra time and staffing input by the administration team and research team required to collate and check all demographic and system-related client data; the planned goal attainment scaling process could not be implemented; gaps in certain information, such as some client activity data that were inadvertently and irretrievably deleted; and the added difficulties and time-consuming nature for the clinical teams and the research team of obtaining supplementary material such as the clinician survey instead of being able to directly access the client files. Due to a number of factors, including unanticipated complications with the DHS computerised client information system, the Take Two computerised system was not operational in 2006. Plans are underway to explore temporary ways to obtain information for the third report in a more efficient manner.

Despite these challenges the research team was able to collect considerable data as described above, and these difficulties did not prevent analysis.

Comparison or control groups can add substantial value to evaluations (Fonagy, et al., 2002); however, comparison groups in this field of practice are extremely difficult to identify. The use of outcome data that include standardised measures, such as the SDQ and the TSCC, allows for comparison with normative populations, and so the lack of a comparison group is not considered a major limitation.

2.11 Summary

This chapter has described the comprehensive methodological approach taken to evaluate the Take Two program and the outcome measures used for children, families and the service system. The evaluation framework highlights the approach to capture and measure complexity through the use of multiple data sources. This chapter has described each of the data collection methods, the reasons for selecting various measures and their development and implementation. The mix of qualitative and quantitative measures provides a strong foundation to assess the nature of the Take Two client group and the impact of Take Two on their wellbeing.
Chapter 3: Ongoing implementation of Take Two - The second year

3.1 Overview
This chapter describes the continued implementation of the Take Two program and the consolidation of the structures and processes in its second year. Major changes to the first year of the program are identified and discussed. The chapter highlights the importance of exploring the structural context of a program in an evaluation.

3.2 The first year
The core establishment task for Take Two in 2003 and 2004 was the creation of a credible and cohesive statewide clinical program, operating from 12 sites in rural and metropolitan Victoria.

This program required instituting management, research and training functions. The initial foci for program design and development was to recruit staff, set up premises and build key relationships at both local and central levels with Child Protection, Child and Adolescent Mental Health Service (CAMHS), Community Service Organisations, schools, Indigenous services and other relevant services. All of this and more was essential for Take Two to achieve its core objectives as stated in the original specifications:

1. To improve outcomes for Child Protection clients through the provision of high-quality services to the client group either directly and/or via work with significant others including family, carers, teachers and peers.
2. To contribute to ongoing development and improvements within the protection, care and therapeutic services as they relate to Child Protection clients.

3.3 Overview of the second year
Once program structures and processes were in place, implementation tasks built on the program development that had commenced in 2003. Programmatic issues identified in 2004 were actively addressed both internally and through discussions with DHS and the advisory processes, such as the Clinical and Program Advisory Group. The second year program development continued to strengthen the clinical role within Take Two whilst placing a growing emphasis on the second objective of contributing to the service system. Programmatic issues discussed in the first evaluation report (Frederico, Jackson, & Black, 2005) which continued to arise during 2005 included the following:

- The physical location of some teams is not always closest to the location of the client group. This led to either extensive travel in some regions or referrals predominantly from certain areas within a region.
- The small size of the rural teams, Aboriginal team and Secure Welfare team, which led to concerns regarding sufficient access to support and limited capacity to meet the demand for service.
- There was limited access to appropriate therapeutic rooms for some teams.
- Delays in receiving the requisite referral documents which impacted on clinical assessments and missing data for the evaluation.
- Critical feedback about the referral documents and process which informed an adapted version of the referral documents. However, this has not yet been able to be operationalised due to difficulties with the interface between the DHS and Take Two information technology systems.
- Need for greater clarity regarding the interface between CAMHS and Take Two.
- The Take Two computerised client information system not being operational.

Table 3 on page 20 provides a summary of the major implementation issues identified and resultant tasks undertaken in 2005.
Table 3
Summary of Implementation Issues and Program Developments during 2005

<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Take Two programmatic response in 2005</th>
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<tbody>
<tr>
<td>Identification of demand for Aboriginal clinicians in Take Two</td>
<td>• Identification of savings within BSV infrastructure budget allowed sufficient recurrent funding for the recruitment of an additional Aboriginal clinician in Take Two in early 2005. There has since been ongoing advocacy regarding the need to expand this statewide team and its work.</td>
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<tr>
<td>Identification of demand in Take Two Secure Welfare role</td>
<td>• Ongoing discussions with DHS regarding the need to fund additional positions in order to meet the emotional and mental health needs of this client group.</td>
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<tr>
<td>Review of the Referral Tool</td>
<td>• Following a review of the Referral Tool changes to the documents were made and implemented into a new computerised format based on InfoPath software. However, difficulties with compliance with the DHS information technology systems delayed implementation. This has been complicated by the introduction of the new Child Protection computerised information system.</td>
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<tr>
<td>Change to reference group processes for central contract management</td>
<td>• In 2004 occasional DHS central reference groups were formed for Take Two. In 2005 a bi-annual forum for Child Protection regional and central management and Take Two managers was required, with emphasis on collaborative operational problem-solving.</td>
</tr>
<tr>
<td>• Two DHS-Take Two forums were held in 2005 as communication mechanisms to provide an overview of ongoing development of Take Two and an interface between Child Protection, Take Two and other key services, such as CAMHS.</td>
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<tr>
<td>In partnership with VACCA, development of the AIATSIS grant regarding assessing Aboriginal children's social and emotional wellbeing</td>
<td>• In partnership with VACCA, Associate Professor Margarita Frederico instigated the successful application for a grant from the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) to develop a means of assessing Aboriginal children's social and emotional wellbeing. The focus in 2005 was participation in a reference group chaired by VACCA that included members of the Take Two Aboriginal team, the Take Two research team and La Trobe University. It successfully applied for the requisite ethics approvals.</td>
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<tr>
<td>Review of client service contract requirements with DHS, and collaborative planning to improve Take Two case turnover</td>
<td>• Reduction of the number of cases expected to be seen by Take Two in a year from 710 to 550. This was more feasible in consideration of the characteristics of the client group, the absence of earlier intervention referrals and reflections on the first year implementation.</td>
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<td>• Emphasised need for referrals that are appropriate for brief intervention as well as longer-term interventions.</td>
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<td>• Take Two and DHS to focus on throughput issues and case closures.</td>
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<tr>
<td>• Improved ‘front end’ collaboration to identify clients most in need of Take Two intervention, via a proactive Help Desk initiative (see later section for further detail).</td>
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<tr>
<td>Review and restructure of Take Two leadership</td>
<td>• Organisational consultant employed to assist Take Two to reflect on its evolution, with a particular focus on decision-making and communication processes, given the particular challenges of wide dispersal of a small staff group and remote management.</td>
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<tr>
<td>• Acknowledgement of the need for internal Take Two leadership structures and processes designed to better facilitate supervision and process staff experiences of vicarious trauma arising from the work.</td>
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<tr>
<td>BSV review of administration systems across BSV</td>
<td>• An internal BSV review led to changes to administrative support provided to Take Two and alignment of administrative structures and processes across BSV including integration of Take Two administration and structure.</td>
</tr>
<tr>
<td>Ongoing development of the Take Two computerised client information system</td>
<td>• Take Two took an operational manager off-line for 3 months to take project responsibility for the establishment of the client information system. However, the system’s finalisation was delayed due to interface issues with the new DHS computerised client information system.</td>
</tr>
<tr>
<td>Analysis of the needs of the first cohort of Take Two clients</td>
<td>• System issues, such as importance of collaboration and number of placement changes for many children noted in 2004 evaluation, highlighted the need for system interventions to be strongly supported.</td>
</tr>
<tr>
<td>• Development and support of care teams (see later section for detail).</td>
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<tr>
<td>Development of the Take Two Practice Framework and the ongoing task of learning about research and other programs that can inform Take Two’s and related fields program and practice development</td>
<td>• System issues, such as importance of collaboration and number of placement changes for many children noted in 2004 evaluation, highlighted the need for system interventions to be strongly supported.</td>
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<tr>
<td>• Development and support of care teams (see later section for detail).</td>
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<tr>
<td>• During 2005, informed by the research profiling of the first intake of clients in 2004, Take Two increasingly focused on client experiences of trauma and disrupted attachment.</td>
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<tr>
<td>• From interviews with external consultants, the views of Take Two staff about appropriate interventions for use with the client group were recorded (see later section for detail).</td>
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<tr>
<td>• Practice refinement was informed by continuing professional development in infant mental health practice; Theraplay; Dyadic Developmental Psychotherapy; and the Sanctuary model of therapeutic residential care.</td>
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(Continued on next page)
3.4 Practice Framework

Ongoing development of the Take Two Practice Framework was a major task during 2005, facilitated primarily by the Take Two Training Manager. The initial Practice Framework document (Downey, 2004), outlined the key practice principles and described the range of possible interventions. The intent, however, has been to build on this through a recursive process including consultation; review of the literature; examination of evidence-based practices; incorporating feedback from staff and others; and trialling various concepts. Developing a framework to encapsulate the work involved with Take Two and to guide clinicians in their assessment and interventions has been both challenging and rewarding. Take Two has brought staff together from a range of disciplines such as psychology, social work, family therapy and psychiatric nursing as well as from a range of fields, such as mental health, child protection, child welfare and sexual assault services. The partnership that holds Take Two also reflects these multiple influences from mental health and child welfare and from practice and academia. As such the development of the Practice Framework has needed to respond to the pragmatic needs of what clinicians require to guide their practice and academia. As such the development of the Practice Framework has needed to respond to the pragmatic needs of what clinicians require to guide their practice as well as providing the philosophical base regarding the essential elements of the work.

One aspect of the ongoing development of the Practice Framework was to utilise consultants to draw together different staff members’ perspectives on practice and their training needs. This review was conducted by Associate Professor Martin Ryan (School of Social Work and Social Policy, La Trobe University) and Sue Jones (research consultant, Sirius Associates). It involved interviews and/or focus groups with Take Two staff. The information gathered, conclusions and recommendations generated by the report informed the Practice Framework. The final report was ‘Maybe it’s time to revisit it: the Take Two staff’s contribution to the review of the Practice Framework’ (Ryan & Jones, 2005). This report describes the range of interventions used by Take Two, areas of achievement and areas of challenge and opportunity regarding practice.

Another source of feedback regarding the Practice Framework came from staff journals completed by a number of Take Two clinicians, especially about assessment. In the early months of 2005 Take Two training focused on a common assessment model. Some clinicians reported on the challenges involved in the model and contributed ideas about the ongoing development of the assessment process. One concern was that a common assessment model for Take Two may be too prescriptive. Journal entries highlight the high level of consideration clinicians gave to assessment and demonstrate a child-focused approach. Overall the journals indicate that clinicians accepted the assessment model and found it useful, if challenging, as the comments below reflect.

To do the assessment in 6 weeks as well as find the client, find the child/young person/ the family, engage them, as well as work through the system’s issues, do the Trauma Checklist, Strengths and Difficulties and Social Network Map, the speech and language questionnaire has been a BIG challenge. (Staff journal)

Another clinician described the value of completing the assessment within the timeframe established in the model.

It is highly beneficial to complete the assessment report quickly. It forces you to think about your client and know in which direction you are heading. It is counterproductive to lengthen the assessment period. One can never fill in all the gaps. First impressions need to be recognised as significant and can often encapsulate all the important issues in a case. (Staff journal)

An example of the conceptual work undertaken regarding the Practice Framework in 2005 was the development of the concept of the draft therapeutic grid as portrayed in Chapter 2. It is proposed in the second stage of the Take Two Practice Framework that the child’s presentation of trauma and the availability of a nurturing and consistent parent or carer are primary indicators regarding what type of therapeutic approach is required. These will be used in concert with a developmental perspective to provide an appropriate focus of the intervention. For example, if a child’s placement is not stable, then this becomes the central focus of intervention before major work can be

| Table 3                                                                 |
| Summary of Implementation Issues and Program Developments during 2005   |
| Issues identified                                                       | Take Two programmatic response in 2005                                    |
| (Continued from previous page)                                          | • The 2004 Creswick Fellowship awarded to the Research Manager provided opportunity to review best practice in North America in 2005. She visited trauma and attachment-informed program and research sites and a series of papers reflect these visits. She has since been invited to become a Child Trauma Fellow enabling ongoing collaboration to occur with the Child Trauma Academy. |
| Began program development of therapeutic farm in partnership with DHS   | • In late 2005, plans began with DHS to establish a new model of providing therapeutic care for children. Take Two has actively participated in the planning process. |
| Demand increasing for training to external services                     | • As Take Two clinical expertise became increasingly recognised across the sector, requests for training increased steadily during 2005. |
| Need for clinical position to be located in Horsham as well as Ballarat | • When a vacancy became available in the Take Two Grampians team, the clinician appointed was located at Horsham, to facilitate access for clients residing in the north-western part of the Grampians region. |
undertaken about the child’s experience of trauma. Certain therapeutic interventions are contra-indicated until a carer/parent figure is available to participate. In those situations interventions may target factors considered likely to influence stability of placement, such as carer’s understanding of the child’s needs and the child’s behavioural presentation. This is further elaborated in Chapter 5 on Interventions.

3.5 Spotlight on the Take Two Aboriginal team

3.5.1 Background

As part of the initial tender process, the Take Two consortium understood the imperative of ensuring that any service for Child Protection clients must be culturally informed about the appropriate way to work with Aboriginal children, their families and their community. The reasons for this include:

- The Convention of the Rights of the Child (1989), Section 30 states that Indigenous children shall not be denied the right to enjoy their own culture. Australia has been a signatory to this convention since 1990. This convention also upholds the best interests of children including their mental health.
- The history of pervasive trauma throughout the Aboriginal community since colonisation, most strikingly in terms of its impact on children, includes the effect of the forced removal of children from their homes and communities on the basis of their Aboriginality, now known as the ‘stolen generations’ (HREOC, 1997).
- The damage that has occurred in the past (and can still occur) when services work with the Aboriginal community in an ill-informed and insufficiently prepared manner (HREOC, 1997).
- The impact of the colonial history is one of the underlying influences on the current disproportionate number of Aboriginal children in the protection and care system. The deeper into the system, the greater the level of over-representation of Aboriginal children (DHS, 2002).
- The history of trauma and deprivation continues to affect the Aboriginal community today in other ways as is exemplified by higher mortality rates (Tatz, 2001); higher rate of childbirth (Trewin & Madden, 2005); lower birth weight (Eades, 2004); lower life expectancy (Trewin & Madden, 2005); greater rates of unemployment, lower wages and inadequate housing (Raphael, Swan, & Martinek, 1998; Pocock, 2004); over-representation in the prison system (Tatz, 2001); and lower access to primary health systems (Zubrick, et al., 2004; Trewin & Madden, 2005).
- Aboriginal young people had significantly more physical and mental health problems and were more likely to engage in lifestyle risk factors than non-Aboriginal young people. (Blair, Zubrick, & Cox, 2005, p. 433)
- Recognition that many Aboriginal children, families and their community are more likely to engage with Aboriginal clinicians.

There is also generally a preference for an Aboriginal worker or advocate within the service who is known within the community or, where these are not available, a non-Aboriginal worker who is known and trusted by other Aboriginal community members and workers who are willing to encourage contact. Information about services or workers who can be trusted is generally passed on by word of mouth through local family and community networks. (Dobson & Darling, 2003, p. 26)

- Australia has one of the healthiest populations in the world, but this contrasts with the Aboriginal and Torres Strait Islander population (Australian Health Ministers Advisory Council’s Standing Committee on Aboriginal and Torres Strait Islander Health Working Party, 2004). Most developed countries with Indigenous populations are showing improvement in health and social wellbeing indicators for their Indigenous peoples, but this is not the case in Australia.
- Australians, in general, are one of the healthiest populations of any developed country, and have access to a world-class health system. At the same time, Australia is also noteworthy in the developed world for its failure to make substantial improvements in the overall health of its Aboriginal and Torres Strait Islander population. This failure stands in marked contrast to the trends in comparable countries such as Canada, the United States and New Zealand. (Australian Health Ministers Advisory Council’s Standing Committee on Aboriginal and Torres Strait Islander Health Working Party, 2004, p. 4)
- The literature review in the initial Take Two evaluation report (Frederico, Jackson, & Black, 2005) described how strong connection with culture is a factor in resilience in the face of trauma and other adverse events.

3.5.2 Development of culturally informed and sensitive program

As a result of the need to develop culturally informed approaches to providing services to Aboriginal children, the appointment of an Aboriginal clinician was incorporated in the original submission by the Take Two consortium. The submission was completed in consultation with VACCA.

As part of its implementation, Take Two established a series of advisory processes including the Aboriginal Reference Group (Frederico, Jackson, & Black, 2005). This group includes representation from VACCA, the Victorian Aboriginal Health Service (VAHS) and the DHS-Indigenous Initiatives Unit. Over the first year of Take Two’s implementation this Reference Group changed in membership and focus and successfully advocated for an additional Aboriginal clinician position. This new position was recruited at the end of 2004 and the successful applicant began in early 2005. As of early 2005, the Aboriginal team consisted of two staff, an Aboriginal Senior Clinician and a clinician.

During 2004 the Aboriginal Senior Clinician’s role included providing direct clinical service. This was most often in collaboration with regional clinicians or with the Secure Welfare Senior Clinician to ensure that their assessment and interventions were culturally appropriate. During 2004 the Aboriginal Senior Clinician also provided cultural awareness training to all staff.
In 2005, a major focus of the Aboriginal team was to develop, train and implement an assessment format to be used by clinicians regarding Aboriginal clients, referred to as the ATSI assessment tool. This tool was developed to ensure more comprehensive and culturally appropriate assessments are conducted by non-Aboriginal Take Two clinicians. It is meant to be used in conjunction with consultation with the Aboriginal team.

The ATSI assessment tool is based on a holistic understanding of Aboriginal health as outlined by the National Aboriginal of Community Controlled Health Organisations (NACCHO).

Health does not simply mean the physical wellbeing of an individual but refers to the emotional, social and cultural wellbeing of the community. For Aboriginal people this is seen in terms of the whole of life view incorporating the cyclical view of life - death - and the relationship to the land. Health care services should strive to achieve the state where every individual is able to achieve their full potential as a human being of their community. (NACCHO, 1993)

Questions within the ATSI assessment tool aim to guide clinicians in their questions of the child’s and family’s connections to the community. It comprises questions regarding the child’s experiences that highlight cultural implications for his or her emotional, social and mental health. It includes protective and risk factors from a cultural perspective. For example, the tool asks about the child’s connectedness to his or her cultural identity, whilst also asking about the family’s experience of the stolen generations. The tool is consistent with the Aboriginal Child Placement Principle by including detail about the child’s placement and opportunities for cultural connectedness within this placement.

The ATSI assessment tool was presented to Take Two clinicians by the Aboriginal team through the ‘Friday Focus’ (regular in-service training) in 2005. An example of feedback from this training is as follows:

Very helpful in helping me think about 1. How to approach my work with my current Aboriginal clients, 2. that I need more specific supervision with the Take Two (Aboriginal clinicians) to better understand and meet the needs of these clients. (Take Two clinician feedback from Friday Focus)

With the expansion of the Aboriginal team, more children were able to be directly allocated to an Aboriginal worker in 2005. However, given the continuing high rate of referrals of Aboriginal children, most were seen by non-Aboriginal clinicians. This emphasises the importance of ongoing collaborative work between the Aboriginal team and the regional or Secure Welfare teams. There were examples where an Aboriginal clinician undertook the cultural assessment and a regional clinician undertook the mental health assessment. These informed each other. In other examples the Aboriginal clinician assisted in the initial engagement of the child and his or her family and community, thus enabling the regional clinician to undertake ongoing therapy. In some situations it was clear from the outset that the best chance for effective engagement and intervention would be by the ongoing involvement of an Aboriginal clinician.

The Take Two Aboriginal team has provided regular consultation to VACCA staff. This has been part of the Help Desk function, as described later in this chapter, and has been primarily in relation to children in the out-of-home care system.

3.6 Spotlight on the Take Two Secure Welfare role

The DHS-Secure Welfare Service was established in Victoria in 1992 and is a unique service within Australia. In the international context there are variations of this type of service in the United Kingdom and the United States, but with major differences. For example, in the United Kingdom, the different statutory authorities such as mental health, youth justice and social services share facilities (O’Neill, 2001). The High Risk Adolescent Services Quality Improvement Initiative report (Success Works, 2001) described residential treatment programs in the United States as providing:

… a purposeful intervention to address the needs of young people in care. According to Bath there are examples of programs which provide well-designed and well resourced therapeutic and educational programs within a caring context. Furthermore, in the USA there are secure or semi-secure adolescent psychiatric facilities, which are largely absent in Australia. (Success Works, 2001, p. 12)

As part of the Creswick Fellowship, the Take Two Research Manager had the opportunity to visit a residential treatment program run by Trillium Family Services in Oregon (www.trilliumfamily.org). This service highlights some of the differences between the systems in the United States compared to Victoria, acknowledging that similar to Australia, different states in the United States vary in terms of context and service system continuum. Trillium’s role in residential treatment has aspects in common with both the Secure Welfare Service and CAMHS inpatient units. A comparison of the residential treatment programs run by Trillium Family Services and the Victorian Secure Welfare Service is outlined in Table 4 on next page.

The Victorian Secure Welfare Service was developed following the de-institutionalisation of large child and adolescent institutions in Melbourne that had previously undertaken both youth justice and child welfare functions. The Children and Young Persons Act 1989 legislated that these functions would be separated.

The function of the Secure Welfare Service is to provide a time-limited strategy to manage high risk situations effectively and meet the needs of the young person. It provides contained, brief periods of stay in a secure setting for young people whose behaviours place them at immediate and serious risk. The DHS Policy and Procedures Manual (1992) states that common factors in young people placed in the Secure Welfare Service include: long history of involvement in out-of-home care; multiple placement breakdowns; abuse and/or neglect; history of chronic drug/alcohol abuse; poor educational and social life skills; disabilities; mental disturbance; medical and health problems; and multiple family problems in basic life areas.

According to DHS policy and consistent with the legislation, the length of placement in the Secure Welfare Service should be the “shortest period consistent with the safety of the young person” and the “minimum necessary to stabilise the young person and return them to a community placement that does not place them at an unacceptable level of risk” (DHS, Policy and Procedures, 1992).

The Secure Welfare Service is available for children and young people aged 10 to 17 years. There is a young women’s and a young men’s Secure Welfare unit each having a ten-bed capacity. In both the Secure Welfare Take Two cases and the general Secure Welfare Service population the majority of admissions are for female clients.

The Victorian Child Death Review Committee Annual Report (VCDRC, 2006) noted that the majority of young people whose deaths had been reviewed by the committee had experienced multiple, out-of-home care placements and short stays in the Secure Welfare Service, in-patient psychiatric services and/or Youth Justice centres.

Several young people in the cases reviewed sought the containment, structure and security of Secure Welfare. This provided a circuit breaker in times of escalating crisis and an opportunity for the young person to rest and regroup. (VCDRC Annual Report, 2006, p. 37)

Morton, Clark, and Pead (1999) highlight the importance of the Secure Welfare Service as a brief contained residential program. They recommend that in some circumstances admission to the Secure Welfare Service is an important adjunct to intensive therapeutic intervention for a young person whose safety is at risk. The VCDRC Annual Report (2006) highlights the need for intensive therapeutic services for adolescents and acknowledges the policy and program development already underway in Victoria to enhance the service system in this area.

The provision of properly supported accommodation for adolescents outlined in Public Parenting (2003) is strongly supported by the facts of the adolescent deaths reviewed in this period. Initiatives such as Take Two, enhancements to the Secure Welfare service model and the establishment of therapeutic foster care should provide a wider set of

<table>
<thead>
<tr>
<th>Table 4</th>
<th>Comparison between the Secure Welfare Service in Victoria, Australia and Trillium Family Services in Oregon, USA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure Welfare Service, Victoria, Australia</td>
<td>Trillium Family Services, Oregon, USA</td>
</tr>
<tr>
<td>State government service.</td>
<td>Non-government service funded by state government and health insurance companies.</td>
</tr>
<tr>
<td>Age group is 10 to 17 years.</td>
<td>Age group is 5 to 18 years.</td>
</tr>
<tr>
<td>Target group is young people who are placing themselves at serious and immediate risk of harm. Must be on some form of interim or longer-term Child Protection court order.</td>
<td>Target group is children and young people with significant mental health problems. Many of these children are Child Protection and/or Youth Justice clients.</td>
</tr>
<tr>
<td>2 X 10 bed units in community in inner suburb of Melbourne.</td>
<td>12 X 12 bed units in two large campus settings one in the city and one in a rural area.</td>
</tr>
<tr>
<td>School co-located with residential setting and funded by Education Department.</td>
<td>School co-located with residential setting and funded by Education Department.</td>
</tr>
<tr>
<td>Is a locked facility with limited ability for young people to leave the site, except under supervision and for specific reasons.</td>
<td>Is a locked facility with limited ability for children and young people to leave the site, except under supervision and for specific reasons.</td>
</tr>
<tr>
<td>Brief to short-term stays with a general maximum of 21 days and in exceptional circumstances up to 42 days. Average length of stay in 2005 was nine days.</td>
<td>Medium to long-term care. Average length of stay is 212 days.</td>
</tr>
<tr>
<td>Perceived as a child protection/child welfare service but with many young people who have a mental health problem.</td>
<td>Perceived as a mental health service but with many young people involved in Child Protection.</td>
</tr>
<tr>
<td>Cannot be used as a Youth Justice setting, but approximately 40% of the young people have involvement with Youth Justice.</td>
<td>Many young people have involvement with Youth Justice. A small number are placed there after they have committed a violent crime yet declared innocent on the basis of insanity.</td>
</tr>
<tr>
<td>Primarily employs residential staff, but has limited access to medical staff. Has access to Alcohol and Other Drug (AOD) Nurses and therapeutic intervention through Take Two and CAMHS.</td>
<td>Employs residential and therapeutic staff, including doctors.</td>
</tr>
</tbody>
</table>
options for young people with significant behavioural disturbance. The VCDRC welcomes these developments and looks forward to monitoring their impact. (VCDRC Annual Report, 2006, p. 38)

The Take Two function in Secure Welfare has developed over time and in partnership between Take Two and the Secure Welfare Service. It was evident early on that another key partner in this process was the Royal Children’s Hospital CAMHS who have traditionally provided mental health consultation and direct service provision to many young people in the Secure Welfare Service. When a child or young person has a mental health case manager from another CAMHS, the protocol is that this worker provides such mental health intervention as required. However, when distance does not allow or when the young person is not a current client of CAMHS, it is generally the Royal Children’s Hospital CAMHS service that provides the mental health role. With the introduction of Take Two providing consultation and therapeutic intervention for these young people there is a potential overlap in services.

There has been considerable work done on building a working relationship between the Take Two role in Secure Welfare and regional CAMHS services. In general, Take Two supports regional CAMHS clinicians (including Intensive Mobile Youth Outreach Service workers) in their work with adolescents in the Secure Welfare Service. The Take Two Secure Welfare Senior Clinician often operates as a liaison between the Secure Welfare Service and CAMHS clinicians, inviting them to case plan processes and to participate in assessments conducted by Take Two with young people. The aim is to provide a strong mental health service link between the young person’s admission into the Secure Welfare Service and subsequent discharge to the community.

CAMHS has continued to contribute directly to the Secure Welfare Service and to the good working relationship with Take Two. In particular the Clinical Director of the Royal Children’s Hospital-Mental Health Service provides on-call psychiatric support to the Secure Welfare Service, often mediated via the Take Two Secure Welfare Senior Clinician. The Clinical Director also provides secondary consultation to the Take Two Secure Welfare role. Regional CAMHS psychiatrists also provide support through primary and secondary consultation.

The Take Two role in Secure Welfare has therapeutic effects in several domains: by drawing together a young person’s fragmented story; making sense of his or her experience and behaviour; and then feeding back to those involved with the care of the young person. Those receiving feedback from Take Two include the young people, their parents, carers, residential care workers, teachers, staff from the Secure Welfare Service and case managers from Child Protection or Community Services Organisations. Young people and those involved in their care can be supported away from any chaos and crisis so that they are able to think about more long-term and less reactive plans for their future.

The Take Two role in Secure Welfare also includes consultation about the care of young people in the ‘here and now’ of the Secure Welfare admission. This role provides support to Secure Welfare Service staff in their everyday management of high risk young people.

3.7 Contributing to service system improvement

As noted earlier, the original specifications for Take Two included the objective of contributing to service system improvement. A major task has been to clarify what this means and how best to achieve it. Service system improvement was seen as a second stage objective as the first imperative was to establish a high quality clinical service. Service system improvement involves incremental goals that require an established clinical reputation as well as robust relationships with key services and networks. Nonetheless, it quickly became clear that contributing to the service system surrounding each child was one of the most frequent clinical goals of the program. It was to this end that a care team approach was adopted within Take Two and implemented in every team. Notwithstanding the value of the service system focus in the clinical work, it remains important to explore how Take Two can best contribute to service system improvement on a broader basis.

To achieve this objective in the first year of operation, Take Two provided training in every region about the referral process, trauma and attachment theory and how these pertain to children who have been abused and neglected. Each DHS regional office established some form of regional advisory process for the implementation of Take Two, which usually incorporated goals and tasks related to broader service system issues. Take Two increasingly received requests for consultations on a case by case basis over the second year of its operation.

As part of its mandate for providing a high quality service as well as contributing to service system improvement, Take Two began a substantial process of knowledge building through extensive literature reviews and consultations with local, interstate and international researchers and practitioners in this field. This included attendance of an Area Manager at a Theraplay training course in London in 2004. It continued in 2005 when the Research Manager was awarded the Creswick Fellowship and travelled to North America. The process of gathering knowledge and learning from international colleagues has formed a platform from which training and other dissemination strategies have developed.

In its second year of operation Take Two initiated and responded to opportunities to expand its work in relation to the broader service system. An internal discussion paper was written within Take Two to explore possible avenues for Take Two’s role in service system improvement. Take Two considered system issues that were perceived barriers to effective outcomes for some children and their networks. Two newly developed functions have been a direct result of the action learning process from the first year; the Help Desk and care teams. These new developments have had both a clinical and service system focus that have been mutually beneficial.

3.7.1 The Help Desk function

Although Child Protection manages the Take Two referral process, Take Two is responsible for proactively supporting this function. In 2005 a process piloted in a couple of teams became instituted across the state. Take Two now provides a visible and regular support for referrals and consultations. This process was coined the Help Desk.
For some teams the Help Desk involved Take Two making a regular time and space where Child Protection workers can seek advice regarding potential referrals or requesting detailed consultations. Where Take Two was already co-located with DHS, the Help Desk was a shorthand way of describing access to advice and consultation. In other regions, Help Desk is a process of phone calls or Take Two attending regular meetings, i.e. a virtual Help Desk. In each region, the best way to provide a Help Desk function was planned with regional Child Protection management to suit local needs and culture. One region initiated a Help Desk process specifically for traumatised infants to raise the profile of their needs. In some regions it was noted that no changes occurred following the offer of a Help Desk as the region considered the established consultation processes satisfactory.

As mentioned earlier, the Aboriginal team established a similar Help Desk function within VACCA. This began by initially visiting VACCA fortnightly and then moving to a more flexible arrangement once the relationship became well established.

Guidelines were endorsed for the implementation and ongoing support of the Help Desk role. An example of the guidelines is:

Take Two regional staff will provide a Help Desk function to regional child protection services. Whilst this function may be provided by telephone and irregular meetings for advice-giving, the Help Desk function in each region should be based on an agreed routine of attendance at Child Protection offices. This attendance should be at least monthly...Local decisions regarding the manner in which the Help Desk function is to be provided should be agreed between the relevant T2 Senior Clinician and Child Protection Manager. (Take Two guideline)

An ongoing difficulty of the referral process is facilitating participation of Community Service Organisations, especially when they hold case management responsibility. Apart from VACCA, Take Two has not been in a position to offer regular Help Desk functions to other Community Service Organisations or within Berry Street Victoria.

It was important to distinguish between providing a Help Desk function and making a referral. The referral documentation as described in the first evaluation report is required for referrals and all decisions are still made by the regional Child Protection Manager or their delegate in partnership with Take Two.

Take Two Help Desk will assist protective case managers with three tasks:

(i) Secondary consultation concerning the intrinsic clinical needs of any Child Protection client
(ii) Triage of potential referrals to Take Two
(iii) Active pre-referral assistance, including collaborative completion of the Harm Consequences Assessment (Part 1 of the Take Two Referral Tool) and collaborative goal-setting for Take Two referral. (Take Two guideline)

Data regarding the consultations that were provided either via the Help Desk or through other means in 2005 are provided in Chapter 5.

3.7.2 The care team approach

A frequent theme regarding children at risk is the importance of effective collaboration between services (Parton, 1995; Wilson & Horner, 2005; VCDRC, 2006). This was a major theme underlying the Victorian Working Together Strategy (DHS, 1999a) and has been especially noted as essential, yet difficult to achieve, when working with high risk adolescents (Morton, Clark, & Pead, 1999) and high risk infants (DHS, 1999b).

Despite the almost universally acknowledged importance of such collaboration it is nevertheless difficult to consistently implement (DHS, 1997; DHS 1999a). Constraints for achieving collaboration include:

- Lack of recognition of the expertise and insight of others by some professionals (Reder, Duncan, & Gray, 1993; HMSO, 1995; Reder & Duncan, 1999).
- Competing tasks and priorities (HMSO, 1995).
- Role confusion within and across professions (Reder, Duncan, & Gray, 1993; HMSO, 1995).
- Complex presentations among the client group (Morton, Clark, & Pead, 1999).
- Lack of interdisciplinary training (HMSO, 1995).
- Unrealistic and incompatible expectations of the roles and functions of others (HMSO, 1995).
- Territorial disputes between services (HMSO, 1995).
- Tight gatekeeping and demand management for a range of services (Armytage, Boffa, & Armitage, 1998).
- Insufficient and irregular contact amongst the professionals (Reder, Duncan, & Gray, 1993).
- Repeated patterns of poor relationships between particular services (Reder, Duncan, & Gray, 1993).
- Pervasive, unchallenged beliefs within closed professional systems (Reder, Duncan, & Gray, 1993).

Working with children who have emotional and behavioural difficulties can involve additional pressures for individual carers and workers. The overall system of carers and workers can feel overwhelmed, isolated and traumatised. The care team is an approach described by Reeder and Cowie (2001) to help harness the efforts of those working with a child at-risk to effect positive and sustaining change and safety. Care teams are also mentioned in the DHS (1998) High Risk Adolescents Services Quality Improvement Initiative Guidelines. Perry (2006) emphasises the complexities of caring for highly traumatised children of all ages and the inadequacy of assuming that a single carer or couple can meet their needs. Perry (2006) writes that providing a therapeutic web around the child and a care team can be the mechanism which ensures support and nurturance is in place.

According to Reeder and Cowie (2001) key components of a care team are:

- regular professional meetings;
- inter-agency planning involving key services;
- use of key workers, where a worker is designated as the primary contact with the child, supported by other workers;
- secondary consultation, where one or more members of the care team who may not have a direct role with the child but take on a regular, supportive and consultative role; and
• agency co-ordinators, where workers take responsibility for facilitating their agency’s response and clarify to others in the care team their organisations’ systems.

A key element in the care team is supporting those directly working with or caring for the child so that they can maintain the necessary level of involvement.

Take Two believes in and promotes a collaborative ‘Care-Team’ approach. It recognises that effective therapy includes work with complex systems. We aim to maintain the stance of ‘a therapeutic mind’, while working with all elements of the system, despite any tensions that may exist. By joining the system in this way the clinician uses their own therapeutic expertise to assist with the processing of the anxieties and dynamics within the system. We do this not as expert advice giver but as participant. If we fail this challenge by becoming the advocate of or aligning with any other element, we give up the possibility of promoting coherent therapeutic interventions and systems health. (Downey, 2006)

Take Two has actively incorporated the use of care teams in the regional and Aboriginal teams. Where possible, the Take Two Secure Welfare Senior Clinician also initiates or supports such care teams. A core goal of the Take Two care team approach is to help those involved ‘keep the child in mind’. These usually include the case manager, teacher, placement worker, Take Two clinician, and where possible, the carer/s. There is some variation across regions. Examples of differences are how regularly care team meetings occur; whether key workers are designated; and the number and role of participants. These variations appear to be a factor of both Take Two and Child Protection practice and provide a useful point for discussion.

Where a care team or some variation is already in place, Take Two becomes an active member providing a therapeutic perspective. In cases where many services are involved, Take Two may recommend a smaller group form the care team. In other cases, Take Two facilitates the establishment of a care team. Following is a quote from a working party document on care teams in the Gippsland Region chaired by DHS with Take Two participation.

A well functioning Care Team could provide the ideal opportunity for creating environments to encourage reflective practice, to develop and test hypotheses about behaviours and to allow those involved with the child/young person to better develop an understanding of the purpose of the behaviours. It was viewed that this would give the team a greater capacity to modify and change behaviours.

The group also identified the need for shared frameworks across DHS services and service providers to better articulate the overall developmental tasks we were assisting the client to achieve, to use some strength based approaches and better utilise the Looking After Children frameworks to develop a shared view and to monitor change. (Gippsland Care Team Working Party, Summary of Progress, Feb 2006)

3.7.3 Participation in networks, reference groups and other forums

Take Two participates in local, state and national networks to inform its work and the work of others. To establish Take Two in each location and service delivery area in 2004, regional or specific advisory and reference groups were established or adapted from already existing groups. These continued in one form or another in most regions in 2005. The Aboriginal Reference Group has been described earlier. The Secure Welfare Service Reference Group began in 2005 with a focus on the therapeutic nature of the Secure Welfare Service as well as Take Two’s role.

As Take Two has become known and formed relationships in each region and across the state, various Take Two staff have been asked to participate in network meetings, reference groups and program and service system development processes. Examples of these networks include involvement in the development of the therapeutic farm initiative in the North and Western and Eastern regions with DHS. Some regions established time-limited working groups to develop processes to resolve emerging difficulties relating to the broader service system. Two regions (North and Western; and Southern regions) had ongoing consultancy panels in which Take Two was a participant.

Other state-based projects in which Take Two was involved include the DHS-convened working group on assessment of complexity of children in home-based care. Take Two was also a participant of a DHS-convened reference group regarding the improvement of residential care outcomes. Take Two also began to develop a national role in 2005. It is represented on the Reference Group of the National Child Protection Clearinghouse (Australian Institute of Family Studies) and the State Advisory Council for Australian Council for Health Standards (ACHS).

3.7.4 Training provided by Take Two to other services and systems

In accordance with the original Take Two specifications as established by DHS, Take Two has a role in providing training to the child protection and related service systems. A training strategy devised in 2004 has continued to develop over 2005 in consultation with Mindful, DHS and Take Two.

As part of the Training Manager’s role and in keeping with the partnership approach underlying Take Two, the Take Two Training Manager is responsible for organising the monthly Friday Forums based at Mindful. Friday Forums are whole day seminars to provide information on current theory and practice for workers in the child, adolescent and family mental health and welfare fields. In 2005, nine topics were covered:

- Recovery from sexual abuse, victims and perpetrators;
- Trauma - current thinking in theory and treatment;
- Youth dual diagnosis;
- Working systemically with hard to place children and young people;
- Early interventions for children with emotional and behavioural difficulties;
- Speech and language development - issues in mental health;
- Working with Aboriginal and Torres Strait Islander families;
- Risky Business - working with violent children and their families; and
- Research in child and adolescent mental health.

Presenters were drawn from Take Two and other organisations including Mindful, Bouverie Family Centre, the University of Melbourne, CAMHS and La Trobe University. Participants in 2005 came from a wide range of sectors and organisations including Child Protection, Youth Justice, education, Community Service Organisations, drug and alcohol services, mental health services, counselling services and the police. Friday Forums continued to be well attended - 334 people in 2005 ($M = 37$ per session). In addition, others accessed the forums through remote site video-conferencing across Victoria and Tasmania, or obtained video recordings of the proceedings.

Take Two presented the Take Two model and some of the findings about the nature of the client group and interventions at a number of conferences in 2005 including:

- **World Conference on Prevention of Family Violence, 23-26 October 2005, Canada.** Paper presented by Annette Jackson: “A Partnership to Develop a New Therapeutic Program for Children who have Experienced Trauma and Disrupted Attachment due to Child Abuse and Neglect.”


- **4th International Conference for Teachers of Infant Observation, 2 September 2005, London, UK.** Paper presented by Jennifer Jackson and Anne Cebon: “No songs from the cradle: Lessons learnt from observing the removed, abandoned or stolen infant”.


- **12th Australasian Society for Traumatic Stress Studies (ASTSS) Conference, Perth, WA, 16-17 September, Poster Presentation by Michelle Houghton regarding Take Two.**

There were specific requests from Community Service Organisations and Child Protection for ‘trauma and attachment’ training. Take Two presented four sessions on trauma offered through the DHS-Child Protection and Youth Justice Professional Development and Training Unit. A total of eight days training was conducted throughout the year. The two-day ‘Children and Trauma’ training includes sessions on historical and cultural perspectives of trauma; the impact of trauma on development; loss and grief; promoting resilience; attachment; and intergenerational patterns of trauma. The two-day ‘Young People and Trauma’ training incorporates similar sessions from an adolescent perspective, and includes a session by the CREATE Foundation (a group run by, with and for children and young people in out-of-home care; www.create.org.au). Feedback from the sessions indicates that the training was well received.

In March 2005, Take Two presented sessions on ‘Disability and Trauma’ for out-of-home care workers and ‘Attachment and Trauma’ to out-of-home care workers in Ballarat. Further sessions on ‘Attachment and Trauma’ for Adoption and Permanent Care staff were also presented.

Take Two staff lectured for the Developmental Psychiatry Course, the University of Melbourne. As part of the Cresswick Fellowship, Take Two presented to a number of organisations in the United States including a lecture at the University of Washington, Seattle. Take Two also conducted lectures to social work and speech therapy students in the Faculty of Health Sciences at La Trobe University and a lecture on child maltreatment to the University of Melbourne.

Take Two has conducted formal training in the application, scoring and interpretation of the SDQ to Child Protection and Community Service Organisations involving training in the Southern Metropolitan and Hume regions.

Take Two has provided sessions to other organisations and services. For example, a Senior Clinician conducted seminars in ‘Attachment Theory’ to Child Protection and Community Service Organisations in Horsham. An Area Manager conducted several sessions in ‘Trauma and Attachment’ for residential unit staff and Community Service Organisations. A Senior Clinician conducted training for a mental health service with regard to High Risk Adolescents and to Child Protection and Community Service Organisations on crisis planning.

### 3.8 Training received by Take Two in 2005

In 2005, the Take Two training strategy continued to be supervised and supported by Mindful. The death of the Director of Mindful, Dr Howard Cooper, in September 2005 deeply affected all who knew him.

As part of the mandate to provide a high-quality service, Take Two has maintained a focus on developing the skills and competencies of staff within the program. This is in keeping with the original specifications regarding the need for highly trained staff to be employed by Take Two. The frequency of the ‘Friday Focus’, the internal statewide professional development day, was reduced to eight per annum to allow for three days of concurrent ‘Area Day’ meetings. Area day meetings are when Take Two teams meet together in groups of three teams across the state to discuss cases and other professional development activities.

The first four Friday Focuses in 2005 concentrated on assessment and formulation including speech and language and assessing Aboriginal clients. The latter Friday Focuses presented Take Two outcome measures and sessions on role clarification, philosophy and the development of the Take Two Practice Framework. The Friday Focus consistently meets its aims, with positive feedback and suggestions for improvement from most clinicians. According to the written feedback received, satisfaction with the Friday Focus training improved in 2005 compared with 2004. Here are some examples of comments by Take Two staff regarding the Friday Focus.

> It’s been interesting to look at how far we have come.  
> Clearly it’s an ongoing process of development.  
> More focus on ‘how’ would be good.
Well presented and exciting to hear about new research developments that will enhance our practice.

It’s great to see our system trying to make the assessment and formulation more streamlined and standardised but part of me felt overwhelmed as the work session raised almost as many questions as we answered!

**Additional professional development**

Take Two clinicians who attend professional development training are expected to present to their teams and at area days. Training attended by various Take Two staff throughout the year included the Sanctuary Model and therapeutic care (Brian Farragher); trauma and dissociation (Elert Nuijenhaus; Daniel Siegel and Louis Cozzolina); and Developmental Dyadic Psychotherapy which is a specific approach with children with seriously disrupted attachments (Daniel Hughes).

Following an Area Manager being trained in Theraplay, Take Two organised Dr Phyllis Rubin and Jean Crume, certified trainers from the Theraplay Institute in the United States, to conduct a four-day training course in late 2005. Take Two funded ten places for clinicians in this training. The training was also offered externally with participants attending from services including Child Protection, Community Services Organisations, private psychology and psychotherapeutic practices, CAMHS and hospitals. Theraplay is used in the treatment of behaviour problems including aggression, attachment disturbances, excessive tantrums, clinginess, fearfulness, self-harming, withdrawal or depression, anxiety, attention difficulties and sensory integration difficulties.

**Higher education**

Many Take Two clinicians undertook study and training in doctorate, masters and post-graduate courses during 2005 including:

- Sixteen clinicians were completing a doctorate or masters course in psychology or family therapy.
- Four clinicians enrolled in the Developmental Psychiatry Course (DPC) at Mindful (the University of Melbourne).
- Four clinicians enrolled in the Graduate Diploma in Child and Adolescent Mental Health offered by Mindful (the University of Melbourne).

By the end of 2005 most of the Take Two staff had completed either the DPC or the Graduate Diploma in Child and Adolescent Mental Health. These are the main courses undertaken by mental health workers within the CAMHS system. They provide core training for such functions as developing formulations, diagnoses and intervention plans within a mental health framework.

**3.9 Summary**

The second year of implementation of Take Two has seen a consolidation of the extensive program development that began in the inaugural year of operation. Internal systems continued to be fine-tuned and tailored to the varying requirements of regions and the statewide focus of the overall program. Initiatives such as the emphasis on the care team approach and the use of the Help Desk highlight the importance of intervening in partnership with the broader system and the value of consultations. These initiatives have been a major development in working towards the objective of service system improvement as well as providing a direct clinical service.

The collaborative partnership within the consortium responsible for Take Two and with DHS central office was essential in working through the challenges inherent in both the development and integration of the program. Some of the tasks are ongoing, such as: exploring the interface between Take Two and CAMHS; sending the message to potential referrers regarding early intervention referrals and referrals regarding younger children; responding to the large demand for Take Two role within Secure Welfare; and enhancing the ability to work culturally respectfully with Aboriginal clients. At the time of writing this report, in 2006 DHS has increased the funding for both Secure Welfare and the Aboriginal teams within Take Two. This provides further opportunity to expand these high demand and much heralded areas of service delivery.
Chapter 4: Who are the children and young people involved with Take Two?

4.1. Overview

This chapter builds on the detailed description of the Take Two client group that began in the previous evaluation report (Frederico, Jackson, & Black, 2005). It provides data regarding some of the demographic information about the client group, their experience of maltreatment, their involvement with the protection and care system, and the emotional, behavioural and developmental presentations as a result of these and other traumatic experiences. This chapter provides a cumulative picture of the first two years of Take Two. Where differences between 2004 and 2005 are found these are highlighted.

Unless otherwise specified, the data in this chapter include Take Two Secure Welfare clients as well as clients of the Aboriginal team and regional teams. Due to the brief nature of the Take Two role in Secure Welfare and the reduced amount of available information, there are instances where data that are available for regional and Aboriginal teams are not available for Secure Welfare.

4.2 An overview of the cases accepted and closed by Take Two in 2004-2005

4.2.1 Cases accepted by Take Two

Over 2004 and 2005 there were 585 cases accepted in Take Two. As shown in Table 5, 197 of the cases accepted in 2004 were still open at the beginning of 2005. With the addition of the 265 new referrals accepted in 2005, the total number of open cases for 2005 was 462 cases. These data indicates that Take Two met 84 percent of the target number of cases set by DHS for 2005, which was 550 cases per year.

The 376 clients of regional and Aboriginal Take Two teams consisted of 230 accepted in 2004 and a further 146 accepted in 2005. After the Secure Welfare role, the highest percentages of cases accepted over the two years were Eastern (11%), Southern (11%) and Western (10%) teams. The Gippsland team showed the highest percentage of accepted cases (7%) for the two years among the rural teams.

There were 197 Take Two Secure Welfare cases accepted over the two years, which constituted a 21 percent increase from 2004 to 2005. This was despite there being only one Take Two staff member allocated to Secure Welfare at this time.

The Take Two Aboriginal team had 12 primary clients over the two years. Two of these clients were accepted in 2004 and a further nine were accepted plus a transfer from a regional team in 2005. The Aboriginal team also provided direct clinical involvement to ten Secure Welfare cases in 2005. In addition, the Aboriginal team was directly involved as a secondary clinician in another seven cases shared with regional teams. The Aboriginal team also provided secondary consultations for many of the Aboriginal children involved with regional Take Two teams. This increase in team workload was consistent with the addition of a second Aboriginal clinician in the team at the beginning of 2005.

4.2.2 Cases closed by Take Two

When analysing the number and percentage of cases closed by Take Two, the Secure Welfare role is considered separately. This is because, as a function of the short-term nature of Secure Welfare admissions, all Secure Welfare cases were closed in less than ten weeks of referral to Take Two. The majority (53%) of Take Two Secure Welfare cases were closed within a week, and 95 percent were closed within five weeks of the referral.

As shown in Table 5, among the regional and Aboriginal teams there was a large variation in the number of cases closed over the two years. These ranged from ten percent of the closed cases being from the Western team compared to the Hume team having no case closures. When considered as a percentage of cases per team, the Western team had the highest rate of closures, with 57 percent of their cases closed in this two-year period. Most regional teams had more case closures in 2005 compared to 2004 which was expected as in 2004 the clinicians’ caseloads consisted of only new cases. Although in overall numbers, the metropolitan teams closed more cases (n = 81) than rural teams (n = 51), when analysed in terms of proportion of cases, there was no difference (35% compared to 36% respectively).
### Table 5
Cases Accepted and Closed by Take Two Team in 2004 and 2005

<table>
<thead>
<tr>
<th>Take Two team</th>
<th>2004 and 2005combined</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases accepted</td>
<td>Cases closed</td>
<td>Accepted cases - closed %</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Barwon South West</td>
<td>29</td>
<td>5.0</td>
<td>14</td>
<td>4.2</td>
</tr>
<tr>
<td>Gippsland</td>
<td>40</td>
<td>6.8</td>
<td>17</td>
<td>5.1</td>
</tr>
<tr>
<td>Grampians</td>
<td>27</td>
<td>4.6</td>
<td>10</td>
<td>3.0</td>
</tr>
<tr>
<td>Hume</td>
<td>20</td>
<td>3.4</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Loddon-Mallee</td>
<td>27</td>
<td>4.6</td>
<td>10</td>
<td>3.0</td>
</tr>
<tr>
<td><strong>Sub-total rural teams</strong></td>
<td>143</td>
<td>24.3</td>
<td>51</td>
<td>15.4</td>
</tr>
<tr>
<td>Eastern</td>
<td>66</td>
<td>11.3</td>
<td>16</td>
<td>4.8</td>
</tr>
<tr>
<td>Northern</td>
<td>43</td>
<td>7.4</td>
<td>6</td>
<td>1.8</td>
</tr>
<tr>
<td>Southern</td>
<td>64</td>
<td>10.9</td>
<td>25</td>
<td>7.6</td>
</tr>
<tr>
<td>Western</td>
<td>60</td>
<td>10.3</td>
<td>34</td>
<td>10.3</td>
</tr>
<tr>
<td><strong>Sub-total metropolitan teams</strong></td>
<td>233</td>
<td>39.9</td>
<td>81</td>
<td>24.5</td>
</tr>
<tr>
<td>Aboriginal</td>
<td>12</td>
<td>2.1</td>
<td>2</td>
<td>0.6</td>
</tr>
<tr>
<td>Secure Welfare</td>
<td>197</td>
<td>33.7</td>
<td>197</td>
<td>59.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>585</td>
<td>100</td>
<td>331</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases accepted</td>
<td>Cases closed</td>
<td>Accepted cases - closed %</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Barwon South West</td>
<td>18</td>
<td>5.6</td>
<td>4</td>
<td>3.3</td>
</tr>
<tr>
<td>Gippsland</td>
<td>19</td>
<td>5.9</td>
<td>3</td>
<td>2.4</td>
</tr>
<tr>
<td>Grampians</td>
<td>16</td>
<td>5.0</td>
<td>4</td>
<td>3.3</td>
</tr>
<tr>
<td>Hume</td>
<td>13</td>
<td>4.1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Loddon-Mallee</td>
<td>21</td>
<td>6.6</td>
<td>4</td>
<td>3.3</td>
</tr>
<tr>
<td><strong>Sub-total rural teams</strong></td>
<td>87</td>
<td>27.2</td>
<td>15</td>
<td>12.2</td>
</tr>
<tr>
<td>Eastern</td>
<td>35</td>
<td>10.9</td>
<td>5</td>
<td>4.1</td>
</tr>
<tr>
<td>Northern</td>
<td>27</td>
<td>8.4</td>
<td>1</td>
<td>0.8</td>
</tr>
<tr>
<td>Southern</td>
<td>39</td>
<td>12.2</td>
<td>8</td>
<td>6.5</td>
</tr>
<tr>
<td>Western</td>
<td>42</td>
<td>13.1</td>
<td>7</td>
<td>5.7</td>
</tr>
<tr>
<td><strong>Sub-total metropolitan teams</strong></td>
<td>143</td>
<td>44.7</td>
<td>21</td>
<td>17.1</td>
</tr>
<tr>
<td>Aboriginal</td>
<td>3</td>
<td>0.9</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Secure Welfare</td>
<td>87</td>
<td>27.2</td>
<td>87</td>
<td>70.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>320</td>
<td>100</td>
<td>123</td>
<td>100</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases accepted</td>
<td>Cases closed</td>
<td>Accepted cases - closed %</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Barwon South West</td>
<td>11</td>
<td>4.2</td>
<td>10</td>
<td>4.8</td>
</tr>
<tr>
<td>Gippsland</td>
<td>21</td>
<td>7.9</td>
<td>14</td>
<td>6.7</td>
</tr>
<tr>
<td>Grampians</td>
<td>11</td>
<td>4.2</td>
<td>6</td>
<td>2.9</td>
</tr>
<tr>
<td>Hume</td>
<td>7</td>
<td>2.6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Loddon-Mallee</td>
<td>6</td>
<td>2.3</td>
<td>6</td>
<td>2.9</td>
</tr>
<tr>
<td><strong>Sub-total rural teams</strong></td>
<td>56</td>
<td>21.1</td>
<td>36</td>
<td>17.3</td>
</tr>
<tr>
<td>Eastern</td>
<td>31</td>
<td>11.7</td>
<td>11</td>
<td>5.3</td>
</tr>
<tr>
<td>Northern</td>
<td>16</td>
<td>6.0</td>
<td>5</td>
<td>2.4</td>
</tr>
<tr>
<td>Southern</td>
<td>25</td>
<td>9.4</td>
<td>17</td>
<td>8.2</td>
</tr>
<tr>
<td>Western</td>
<td>18</td>
<td>6.8</td>
<td>27</td>
<td>13.0</td>
</tr>
<tr>
<td><strong>Sub-total metropolitan teams</strong></td>
<td>90</td>
<td>33.9</td>
<td>58</td>
<td>28.8</td>
</tr>
<tr>
<td>Aboriginal*</td>
<td>9</td>
<td>3.4</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>Secure Welfare</td>
<td>110</td>
<td>41.5</td>
<td>110</td>
<td>52.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>265</td>
<td>100</td>
<td>208</td>
<td>100</td>
</tr>
</tbody>
</table>

Note: One of the referrals listed under the Aboriginal team in 2004 was a Hume team case in 2004 and transferred to the Aboriginal team in 2005.
The length of time closed cases had been open among the regional and Aboriginal teams was, on average, ten months (SD = 6.1). Sixteen percent of closed cases were open for less than three months and a further 19 percent were open between three and six months. Twenty-five percent of closed cases had been open between six months and a year; 29 percent were open between 12 and 18 months; and the remaining ten percent were open for two years.

Among the eight regional teams with case closures and the Aboriginal team, the greatest variation was evident in the percentage of cases closed within three months. Barwon South West, Grampians, Loddon-Mallee, Northern and the Aboriginal teams had no closures in less than three months. In contrast the Eastern team closed ten cases within three months of acceptance. This accounted for 63 percent of their closed cases, although eight were in relation to one sibling group. Western, Gippsland and Southern teams had six (17%), five (29%) and one (4%) case/s closed respectively during the first three months.

Over the two years, among regional and Aboriginal team cases the most frequent reason for case closure was the completion of Take Two’s role (58% of closed cases). This was the most common reason regardless of length of Take Two involvement. Among cases that had been open a year or more this reason for case closure was even more frequent, accounting for nearly three quarters of closed cases (74%). Another service being deemed more appropriate than Take Two was the reason for closure of 16 percent of cases and a further 13 percent were closed due to the client or client’s family refusing Take Two service. The remaining 13 percent of cases were closed because Child Protection had closed the case. Take Two is required to close within three months of Child Protection ceasing involvement.

Although not statistically significant, there were some indications of differences among Aboriginal and non-Aboriginal clients in relation to reasons for closure. Among Aboriginal clients (not including Secure Welfare), the percentage of cases that closed due to the completion of Take Two’s role was lower than among non-Aboriginal clients (43% compared to 60%). The percentage of Aboriginal clients was higher than non-Aboriginal clients for cases closed due to another service being considered more appropriate (21% compared to 15%) and following Child Protection closing (21% compared to 12%). A similar percentage of Aboriginal and non-Aboriginal client cases closed because the client or client’s family refused the service (14% compared to 13%).

The percentage of cases closed by the regional and Aboriginal teams due to completion of Take Two’s role increased considerably from cases referred in 2004 (53%) to cases referred in 2005 (83%). The percentage of cases closed because another service was considered more appropriate reduced from 17 percent of closed cases referred in 2004 to eight percent for closed cases referred in 2005. No closed cases referred in 2005 were closed due to the clients or their family refusing the service, compared with 16 percent of closed cases referred in 2004. The percentage of cases that closed due to Child Protection ceasing involvement reduced from 14 percent of closed cases referred in 2004 to 8 percent of closed cases referred in 2005. Taken together, these changes suggest a positive trend in more appropriate referrals being made to Take Two over time and/or the ongoing development of the Take Two service regarding quality of practice.

4.2.3 Daily average number of cases

As shown in Table 6, the daily average number of cases open in 2005 for Take Two was 238, with a marked increase each quarter, from 209 for the first quarter culminating with a daily average of 265 cases open during the October to December quarter of 2005. In 2005, the target set by DHS was a daily average of 297 clients. While this was not reached, with 80 percent of the annual target met, there was a clear pattern of an increasing daily average over time increasing from 70 percent in the first quarter to 89 percent in the fourth quarter in 2005.

### Table 6

<table>
<thead>
<tr>
<th>Take Two team</th>
<th>Quarterly Average</th>
<th>2004 Annual Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jan-Mar</td>
<td>Apr-June</td>
</tr>
<tr>
<td>Barwon South West</td>
<td>5.6</td>
<td>12.8</td>
</tr>
<tr>
<td>Gippsland</td>
<td>3.7</td>
<td>6.3</td>
</tr>
<tr>
<td>Grampians</td>
<td>4.7</td>
<td>10.8</td>
</tr>
<tr>
<td>Hume</td>
<td>5.3</td>
<td>8.8</td>
</tr>
<tr>
<td>Loddon-Mallee</td>
<td>9.1</td>
<td>16.7</td>
</tr>
<tr>
<td><strong>Sub-total rural teams</strong></td>
<td><strong>28.4</strong></td>
<td><strong>55.3</strong></td>
</tr>
<tr>
<td>Eastern</td>
<td>12.4</td>
<td>24.7</td>
</tr>
<tr>
<td>Northern</td>
<td>10.5</td>
<td>18.3</td>
</tr>
<tr>
<td>Western</td>
<td>9.3</td>
<td>31.3</td>
</tr>
<tr>
<td>Southern</td>
<td>11.8</td>
<td>32.6</td>
</tr>
<tr>
<td><strong>Sub-total metropolitan Teams</strong></td>
<td><strong>44.0</strong></td>
<td><strong>106.9</strong></td>
</tr>
<tr>
<td>Aboriginal</td>
<td>0.6</td>
<td>1.8</td>
</tr>
<tr>
<td>Secure Welfare</td>
<td>3.4</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>76.4</strong></td>
<td><strong>166.5</strong></td>
</tr>
</tbody>
</table>

(Continued on next page)
In 2005, among the rural teams the annual daily average ranged from 15 to 18 cases open. Among the metropolitan teams the average ranged from 32 to 43 cases open. This was a major increase in daily average compared to the first year of operation in 2004. Given the smaller size of the rural teams it was expected that they would have smaller daily average caseloads per team. In 2005, on average staff in the rural teams had a caseload of 5.5 and staff in the metropolitan teams had an average caseload of 7.3 cases.

When analysing the changes over 2005, rural teams increased from an average caseload of 4.7 cases per clinician in the first quarter of 2005 to 6.9 cases by the last quarter of that year. Metropolitan teams increased from an average caseload of 6.7 cases per clinician in the first quarter of 2005 to 9.2 cases by the last quarter. The Aboriginal team increased from an average of 2.4 primary cases per clinician to 6.2 cases by the final quarter of the year. The Secure Welfare position averaged 11 cases over the year. Fluctuations were dependent largely on whether the sole Secure Welfare Senior Clinician took leave during a particular quarter.

Overall, the clinicians’ caseloads reflect the severity and the complexity of many of the cases that are the focus of their interventions. This will be described in more detail later in this chapter.

4.2.4 Repeat referrals to Take Two

The target set by DHS of the number of re-referrals Take Two could accept within 12 months of closure was 10 percent or less. This target does not include Secure Welfare referrals given the nature of Secure Welfare and the repetition of admissions required for some young people.

This target was met in both 2004 and 2005. Not including Secure Welfare cases, only four cases have been re-referred to Take Two within a year of the case being closed, resulting in a re-referral rate of one percent over the two years and two percent for cases accepted in 2005.
4.3 Description of the children involved in the Take Two program

4.3.1 Age and gender of Take Two clients

Over half (55%) of Take Two clients were aged 12 years or older at the time of referral (see Figure 7). There was a significant increase in the average age of clients from referrals in 2004 ($M = 11.1$ years, $SD = 4.4$) to clients referred in 2005 ($M = 12.3$ years, $SD = 3.8$; $t(583) = 3.56$, $p < .001$). This change relates to the average age of clients of the regional and Aboriginal teams increasing in 2005. This was alongside the increase in the number of Secure Welfare clients, where there was no change in the average age of clients, of 15.1 years in both 2004 and 2005.

It was noted in the first evaluation report (Frederico, Jackson, & Black, 2005) that the small percentage of infants and young children referred to Take Two was a concern. Unfortunately infant referrals to Take Two in 2005 made up an even smaller percentage of referrals than in 2004. In 2004 eight percent of regional referrals were for children under three years and in 2005 this figure had decreased to three percent. Only three teams had more than one infant referral over the two years; Northern team with four, Western team with five and Southern team with eight infants.

All teams except Secure Welfare and the Aboriginal team had at least one referral for children aged between three and six years. Among the rural teams this varied from the Hume team which had one client (5% of Hume team caseload) to the Grampians team which had five clients aged between three and six years (19% of Grampians team caseload). Among the metropolitan teams there was a large variation ranging from the Northern team which had four clients (9% of Northern team caseload) to the Western team which had 15 referrals for children aged between three and six years, accounting for 25 percent of their caseload over the two years.

Although over half (55%) of all Take Two clients were male in 2004 and 2005, there was a significant change in the gender ratio within these two years ($\chi^2(1) = 7.09$, $p < .05$). Sixty percent of clients referred in 2004 were male and in 2005 this had reduced to 40 percent. This difference is accounted for when analysing Secure Welfare referrals. In 2004, 45 percent of Secure Welfare clients were male and in 2005 this had reduced to 34 percent. This change was largely due to the major increase of young women in Secure Welfare. Among the Aboriginal and regional teams there was a small reduction from one year to the next in the ratio of males, although they were still the majority. In 2004, 65 percent of the Aboriginal and regional teams’ clients were male compared to 59 percent in 2005. Among the Aboriginal and regional teams, the higher proportion of male clients related to children aged between 3 and 15 years.

Over the two years all teams except Secure Welfare had a majority of male clients referred, ranging from 52 percent of Loddon-Mallee clients to 76 percent of Barwon South West clients.

4.3.2 Aboriginal children

Take Two has received referrals for 90 Aboriginal children, representing 15 percent of all clients referred to Take Two during 2004 and 2005 (see Table 7). Twelve of these clients were allocated to the Aboriginal team, 36 were Secure Welfare clients and the remaining 42 were clients of regional teams. As stated earlier, ten of those in Secure Welfare received a joint service from the Secure Welfare position and the Aboriginal team.

Although not statistically significant there was a greater percentage of Aboriginal clients referred in 2005 (17%) than 2004 (14%). This is partially explained by the growth in staffing of the Aboriginal team in 2005 and the subsequent ability to increase referrals to the team from two cases in 2004 to ten cases in 2005. In addition to the Aboriginal team, referrals for Aboriginal children to regional teams increased from 10 percent in 2004 to 14 percent in 2005. This may also be influenced by the increased profile of Take Two in working with Aboriginal children because of the training and consultation work undertaken by the Aboriginal team.
On one hand these are alarming figures given the Aboriginal population represents only 0.6 percent of the Victorian population, although Aboriginal children are over-represented in the out-of-home care population, where they were 12 percent of that population in Victoria in 2002 (DHS, 2005). Another perspective on these figures is that the increase in referrals to Take Two is a positive indication that the service system is recognising the need for Aboriginal children to have access to appropriate therapeutic interventions.

### Table 7
**Aboriginal Children Referred to Take Two by Type of Team in 2004 and 2005**

<table>
<thead>
<tr>
<th>Type of team</th>
<th>2004</th>
<th>2005</th>
<th>2004 &amp; 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Aboriginal team</td>
<td>3</td>
<td>100</td>
<td>9</td>
</tr>
<tr>
<td>Regional teams</td>
<td>22</td>
<td>9.6</td>
<td>20</td>
</tr>
<tr>
<td>Secure Welfare</td>
<td>19</td>
<td>22.1</td>
<td>17</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>44</strong></td>
<td><strong>13.8</strong></td>
<td><strong>46</strong></td>
</tr>
</tbody>
</table>

Note. One of the referrals listed under the Aboriginal team in 2004 was a Hume team case in 2004 and transferred to the Aboriginal team in 2005.

All Take Two teams worked with Aboriginal children over the two years. Nearly a fifth (18%) of Secure Welfare clients were Aboriginal. Among the regional teams, the Gippsland team had the largest percentage of Aboriginal clients, making up 30 percent (n = 12) of their clients, followed by the Southern team with 16 percent (n = 10). The only other regional team to have more than two Aboriginal clients was the Western team with six Aboriginal children (10% of Western team caseload).

Over two thirds (69%) of Aboriginal clients were 12 years or older, a larger majority than the age range of clients of Take Two as a whole. The mean age of Aboriginal clients (12.4 years) was significantly higher compared to non-Aboriginal clients (10.9 years), ($X^2(2)8.56 = p < .05$). No Aboriginal infants were referred to Take Two. This is in sharp contrast to the high proportion of Aboriginal children who are under the age of five years in the overall Aboriginal population (DHS, 2005).

Unlike the Take Two client population as a whole, there were more female Aboriginal clients (54%) than male clients; however, this is influenced by the number of Aboriginal female clients referred to the Secure Welfare Service. Among Aboriginal regional clients the majority (56%) were male.

#### 4.3.3 Siblings

As shown in Table 8, according to Child Protection records, fewer than ten percent of Take Two clients in 2004 and 2005 had no siblings (including full, half and step siblings). On average, each child had 2.6 siblings. Fifty percent of the children had three or more siblings, including one child with 11 siblings. Among children who had at least one sibling, 66 percent were not living with any of them. Among children who had at least one sibling, the large majority (88%) had at least one sibling who was also a client of Child Protection.

It was difficult to find other data for comparison regarding number of siblings. The Home-Based Care Audit (DHS, 2001a) found an average of 1.4 siblings per child. However, it is not known if this included half and step-siblings. Both the Home-Based Care Audit (DHS, 2001a) and the Audit of Kinship Care Clients (DHS, 2001b) found that not all of the child’s siblings were listed in the Child Protection records. Therefore, it is possible that the data shown in Table 8 are an under-representation of the number of siblings.

### Table 8
**Number of Siblings for all Take Two Clients in 2004 and 2005**

<table>
<thead>
<tr>
<th>Number of siblings (N = 556) - 2004 &amp; 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>N</td>
</tr>
<tr>
<td>%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of siblings living with child at time of referral (N = 503) - 2004 &amp; 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
</tr>
<tr>
<td>%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of siblings involved with Child Protection (N = 503) - 2004 &amp; 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
</tr>
<tr>
<td>%</td>
</tr>
</tbody>
</table>

Note. Number of siblings living with child and number of siblings involved with Child Protection includes only children who had at least one sibling.
4.3.4 Children living in rural or metropolitan settings

Two thirds of the children (67%) involved in Take Two lived in metropolitan Melbourne compared to a rural area. This included those who were clients of the statewide teams; namely, Secure Welfare and the Aboriginal team. There were no significant differences found between children living in either metropolitan or rural areas in relation to gender, Aboriginal identity or type of Child Protection involvement. The average age of children was significantly younger in rural areas than in metropolitan settings \((t(4) = 27.53, p < .001)\). Children in the metropolitan areas were more likely to be living at home or in residential care compared to rural areas. In contrast, children in rural areas were more likely to be placed in kinship care or home-based care.

4.3.5 Children’s experience of loss and grief

As found in the previous evaluation (Frederico, Jackson, & Black, 2005), many children involved in the protection and care system have also experienced other traumatic events and suffered severe loss, such as the death of a parent or sibling. As the clinicians were not interviewed for this evaluation, the same level of detail was not available in the previous report. However, information was collected from Child Protection records (Client Profile Documents) and validated via the Take Two Senior Clinicians regarding whether or not the children had one or more deceased parent-figures. This information was not available for Secure Welfare clients.

Over the first two years of Take Two’s operation, 52 children (14%) had a mother \((n = 20)\), father \((n = 28)\) or step-father \((n = 5)\) who was deceased. There was major variation across the teams, with the Western team having 18 children who had a deceased parent. This is nearly a third \((31\%)\) of this team’s caseload. This was followed by the Eastern team with nine children \((14\%\) of the team’s caseload) and Loddon-Mallee and Southern teams with seven children \((27\%\) and 11\% of their teams’ caseloads respectively) who had a deceased parent.

Child Protection records indicate that at least another 12 children have one or more siblings who were deceased.

4.4 Children’s experiences within the protection and care system

4.4.1 History of Child Protection involvement

The large majority of children involved with Take Two have extensive histories of child protection involvement by the time they are referred to Take Two. Figure 8 illustrates the number of notifications, investigations, substantiations and court orders for all Take Two clients. Nine percent of clients had not been notified to Child Protection prior to their current involvement. For this small proportion of children with one-off involvement, some had a continuous Child Protection history for over ten years. The majority \((65\%)\) had their first notification to Child Protection between 2002 and 2004, but this was partly a function of age with nearly two thirds of these children aged eight years or younger.

Figure 8. Previous Child Protection involvement at time of referral for all Take Two clients in 2004 and 2005

\((N = 553)\)

<table>
<thead>
<tr>
<th>Child Protection involvement (does not include Child Protection involvement at time of referral)</th>
<th>None</th>
<th>1</th>
<th>2</th>
<th>3–4</th>
<th>5–9</th>
<th>10–14</th>
<th>15–19</th>
<th>20+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notifications</td>
<td>20%</td>
<td>14%</td>
<td>18%</td>
<td>13%</td>
<td>9%</td>
<td>12%</td>
<td>32%</td>
<td>32%</td>
</tr>
<tr>
<td>Investigations</td>
<td>19%</td>
<td>14%</td>
<td>18%</td>
<td>13%</td>
<td>9%</td>
<td>12%</td>
<td>32%</td>
<td>32%</td>
</tr>
<tr>
<td>Substantiations</td>
<td>11%</td>
<td>7%</td>
<td>11%</td>
<td>6%</td>
<td>0.5%</td>
<td>14%</td>
<td>21%</td>
<td>21%</td>
</tr>
<tr>
<td>Court Orders</td>
<td>17%</td>
<td>7%</td>
<td>17%</td>
<td>7%</td>
<td>0.2%</td>
<td>17%</td>
<td>21%</td>
<td>21%</td>
</tr>
</tbody>
</table>

Nearly half \((49\%)\) of all children who were clients of Take Two had five or more previous notifications prior to their current involvement with Child Protection, with one child aged nine years, having 29 previous notifications, beginning soon after the time of his birth.

The large majority \((86\%)\) of children had at least one previous investigation, including 55 percent who had three or more previous investigations. Six percent of children had previously been investigated on 10 or more occasions prior to their current Child Protection involvement, with the most being 16 previous investigations.

Over two thirds \((68\%)\) of children had at least one substantiated abuse prior to their current Child Protection involvement, with 28 percent having three or more previous substantiations. The highest number of previous substantiations was nine, for a 13-year-old girl.

Two thirds \((66\%)\) of the children had been on a previous court order, including nearly a quarter \((24\%)\) who had been on three or more previous court orders. A 15-year-old Take Two Secure Welfare client had been on 19 previous court orders (not including Interim Accommodation orders or Youth Justice orders).

The only significant difference regarding Child Protection involvement over 2004 and 2005 was that on average the
children referred in 2005 had fewer previous substantiations (2004: $M = 4.5$, $SD = 3.6$; 2005: $M = 2.9$, $SD = 2.6$; $t(551) = 5.99$, $p < .001$). Once age was accounted for there were no significant differences between regional and Secure Welfare cases.

As expected and shown in Table 9, younger children had a less extensive history than older children; children aged five years and less had fewer notifications, investigations and substantiations than older children. However, there were no differences found between children aged between 6 and 12 years compared with children aged 12 years and over. In other words, children between the ages of 6 and 12 years are likely to have a similarly extensive history of Child Protection involvement as adolescents. There was no significant difference in the number of court orders among the different age categories. For example, infants were likely to have been placed on almost as many court orders as older children.

### Table 9

**Means, Standard Deviations and ANOVAs regarding Child Protection Involvement and Age of all Take Two Clients in 2004 and 2005**

<table>
<thead>
<tr>
<th>Age groups</th>
<th>Notifications</th>
<th>Investigations</th>
<th>Substantiations</th>
<th>Court Orders</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-&lt;6 years</td>
<td>$M = 2.3$</td>
<td>$M = 2.0$</td>
<td>$M = 0.6$</td>
<td>$M = 1.2$</td>
</tr>
<tr>
<td></td>
<td>$SD = 2.4$</td>
<td>$SD = 2.3$</td>
<td>$SD = 0.9$</td>
<td>$SD = 1.3$</td>
</tr>
<tr>
<td>6-12 years</td>
<td>$M = 5.6$</td>
<td>$M = 4.2$</td>
<td>$M = 1.7$</td>
<td>$M = 1.6$</td>
</tr>
<tr>
<td></td>
<td>$SD = 4.6$</td>
<td>$SD = 3.3$</td>
<td>$SD = 1.7$</td>
<td>$SD = 1.6$</td>
</tr>
<tr>
<td>12-18 years</td>
<td>$M = 6.0$</td>
<td>$M = 3.9$</td>
<td>$M = 1.9$</td>
<td>$M = 1.7$</td>
</tr>
<tr>
<td></td>
<td>$SD = 4.6$</td>
<td>$SD = 3.3$</td>
<td>$SD = 1.9$</td>
<td>$SD = 1.9$</td>
</tr>
<tr>
<td>Test of significance, ANOVA</td>
<td><strong>Significant - $F(2, 550)=21.24$, $p&lt;.001$</strong></td>
<td><strong>Significant - $F(2, 550)=13.14$, $p&lt;.001$</strong></td>
<td><strong>Significant - $F(2, 550)=14.87$, $p&lt;.001$</strong></td>
<td><strong>Not significant - $F(2, 551)=2.17$, ns</strong></td>
</tr>
</tbody>
</table>

There were no significant differences in Child Protection histories between Aboriginal and non-Aboriginal children.

### 4.4.2 Child Protection involvement at time of referral to Take Two

Figure 9 shows that only six percent of children were not on a Children’s Court order at the time of referral in 2004 and 2005. A greater percentage of children aged 12 years and older were on a court order at this time, compared to younger children (0-<6 years 89% on court orders; 6-<12 years 90% on orders and 12-<18 years 97% on orders). (X²(2)=12.05 = $p < .01$). However, amongst all age groups, the large majority of children were on a court order at the time of referral to Take Two.

Forty-three percent of children in 2004 and 2005 were on Custody to Secretary orders, followed by 20 percent on Guardianship orders and 17 percent on Interim Accommodation orders at the time of referral to Take Two. All other orders accounted for less than five percent of Take Two clients. In other words, two thirds of the Take Two population were on long-term court orders.
4.4.3 History of children’s placements

Figure 10 shows the number of previous placements (not including their current placement) at the time of referral to Take Two in 2004 and 2005. These data were from Child Protection records (Client Profile Document). Only nine percent of children had not had a previous placement at the time of referral to Take Two. The majority of children (59%) had five or more previous placements. One child had 45 previous placements. Twenty-four children (4%) had at least one previous permanent care placement which had since ceased and they were moved to alternative care.

According to Child Protection records, 330 (65%) of the children who had been removed from home subsequently experienced one or more attempts at reunification prior to referral to Take Two. As shown in Figure 11, this included 27 percent who had one home return; 19 percent who were returned home twice; nine percent had three attempts and ten percent had been returned home four or more times. The range of reunification attempts was from zero to eight.

An alarming finding was that 310 children (94% of those who had been reunited) had been removed from home at least one more time after being reunited with their family. In other words, only twenty children who had been reunited had remained with their family up to the time of referral to Take Two. There were no significant differences between these 20 children and those who experienced unsuccessful reunification. The 20 children who had remained at home following reunification ranged in age from 1 to 15 years, with the most common age group being 15 years of age (M = 11.2 years, SD = 4.5). They were equally divided in terms of gender and only two (10%) were Aboriginal. A difference between this group and the general Take Two population was that they were more likely to be on a shorter-term order, such as an Interim Accommodation Order or Supervision Order. Only one of these children was on a Custody to Secretary Order.
4.4.4 Placement at time of referral

At the time of referral to Take Two in 2004 and 2005, the majority of children were either in home-based care (30%) or residential care (27%). A further 20 percent of children were living with one or both of their parents and 15 percent were in kinship care at time of referral. This is shown in Table 10.

<table>
<thead>
<tr>
<th>Placement</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living with one or both parents</td>
<td>110</td>
<td>20.2</td>
</tr>
<tr>
<td>Kinship care</td>
<td>82</td>
<td>15.1</td>
</tr>
<tr>
<td>Home-based care</td>
<td>165</td>
<td>30.3</td>
</tr>
<tr>
<td>Residential care</td>
<td>149</td>
<td>27.4</td>
</tr>
<tr>
<td>1:1 care</td>
<td>7</td>
<td>1.3</td>
</tr>
<tr>
<td>Independent Living</td>
<td>5</td>
<td>0.9</td>
</tr>
<tr>
<td>Permanent Care</td>
<td>8</td>
<td>1.5</td>
</tr>
<tr>
<td>No fixed address</td>
<td>5</td>
<td>0.9</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>2.6</td>
</tr>
<tr>
<td>Total</td>
<td>545</td>
<td>100</td>
</tr>
</tbody>
</table>

Note. ‘Other’ includes children living in: lead tenant, a Youth Justice centre or a refuge.

A significant difference was found between the age of children and their placement at the time of referral to Take Two in 2004 and 2005 ($X^2(8)85.65 = p < .001$). Children under the age of 12 years were less likely to be in residential care, especially children under the age of six. In contrast, children under the age of 12 years were more likely to be in home-based care compared to young people aged 12 years or older. Nevertheless, there were three children under the age of six years in residential care.

There was no significant difference across age groups in terms of living with one or both parents, although children under the age of six were slightly more likely to be at home and children over the age of 12 slightly less likely. Children between the ages of 6 and 12 years were significantly more likely to be in kinship care ($X^2(19)50 = p < .01$), whereas those under the age of six were only slightly more likely. Those children aged 12 years and older were slightly less likely to be in kinship care.

4.4.5 Case contracted case management

Eighteen percent of clients of the regional and Aboriginal teams for 2004 and 2005 were case managed by Community Service Organisations. There was too much missing data to determine this for Secure Welfare clients. Although there was a slight increase, there was no significant difference between the two years in relation to percentage of cases where case management was contracted.

As the majority of children involved with Take Two are on a Guardianship or Custody to Secretary order, which are usually highly represented in cases that are contracted, there is a query regarding this relatively low percentage. One hypothesis, based on feedback from Community Service Organisations during the previous evaluation (Frederico, Jackson, & Black, 2005), is that not all such services realised that they could make referrals to Take Two, albeit via Child Protection. Another hypothesis is that this could reflect the different nature of the cases that are contracted compared to those where case management is held by Child Protection. However, it appears that patterns of case contracting vary across and within regions. For example, case contracting occurs for both high-risk and highly stable cases, both of which may represent a child who would benefit from therapy.

There was no significant difference between metropolitan and rural cases as to whether or not case management was contracted to a Community Service Organisation and whether the child was Aboriginal. This is in contrast to the first year of operation where case management of Aboriginal children was significantly more likely to be contracted. One pattern that has not changed over the two years is that the older the child the significantly more likely they are to have their case management contracted to a Community Service Organisation ($X^2(15)36 = p < .001$).

4.4.6 Child Protection case plan goals

Table 11 shows Child Protection case plan goals for the clients of the regional and Aboriginal teams across 2004 and 2005 according to the referral documentation. These data were not available for Secure Welfare clients. The pattern has continued over the two years with reunification as the most frequently cited case plan goal. This was followed by the goal of remaining with families, then some form of long-term placement and then permanent care. This reflects both the reality that most of these children are in placement and that many have been in placement for a long period of time.

Take Two is unable to work with children once they are on a Permanent Care order, as they no longer meet the criteria of being clients of Child Protection. However, Take Two works with a substantial group who are planned for permanent care and/or who are already in a permanent placement, but are not as yet on a Permanent Care order.
4.5 Young people within the Take Two Secure Welfare Service

Some of the demographic data regarding the young people who were clients of Take Two Secure Welfare have been mentioned earlier in this chapter, but in summary for 2004 and 2005:

- The mean age of clients of Take Two Secure Welfare was 15.1 years.
- 61% were female.
- 18% were Aboriginal young people.
- As required all young people admitted into the Secure Welfare Service were on a Children’s Court (family division) order.
- The majority were on Custody to Secretary orders (52%), followed by Interim Accommodation orders (26%) and then Guardianship orders (18%). The remaining orders were different types of breached orders. There were similar Child Protection histories reflecting multiple notifications, investigations, substantiations and court orders compared with young people of similar age who were clients of other Take Two teams.
- Prior to admission into the Secure Welfare Service, half were in residential care (49%), followed by 16% living with one or both parents, 13% living in some form of home-based care and 15% being in another type of placement.

Table 12 shows that the age of those seen by Take Two Secure Welfare are reasonably similar to the population of the general Secure Welfare Service with 77 percent being 14 years or older in both the population of the overall Secure Welfare Service and of Take Two Secure Welfare.
The percentage of young people in Take Two Secure Welfare who are Aboriginal has decreased over the two years by eight percent. Nevertheless, the overall figure of 18 percent is a larger over-representation than the general Child Protection population, though consistent with the population of the Secure Welfare Service.

As noted earlier in this chapter, the number of young women in the Secure Welfare Service in general and in the Take Two Secure Welfare population increased by ten percent from 2004 to 2005.

Once age was taken into consideration, there was no significant difference in the extensive Child Protection histories between the young people involved with Take Two in Secure Welfare and the overall Take Two client group. The majority of young people were on long-term court orders.

This pattern did not change from 2004 to 2005 and was consistent with the general population of the Secure Welfare Service.

Prior to admission to the Secure Welfare Service, over the two years nearly half the Take Two Secure Welfare clients were in residential care, with the next highest number living with one or both parents, followed by those living in home-based care. The percentage of those in residential care prior to admission increased over the two years by 12 percent to 55 percent in 2005.

As seen in Table 13, the use of the Secure Welfare Service in general and for Take Two’s role within this service varies considerably by Child Protection region, with the substantial majority (74%) coming from metropolitan regions.

<table>
<thead>
<tr>
<th>Child Protection region</th>
<th>T2 Secure Welfare</th>
<th>General Secure Welfare Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Barwon South West</td>
<td>5</td>
<td>2.5</td>
</tr>
<tr>
<td>Gippsland</td>
<td>6</td>
<td>3.0</td>
</tr>
<tr>
<td>Grampians</td>
<td>7</td>
<td>3.6</td>
</tr>
<tr>
<td>Hume</td>
<td>19</td>
<td>9.6</td>
</tr>
<tr>
<td>Loddon-Mallee</td>
<td>14</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>Sub-total rural regions</strong></td>
<td><strong>51</strong></td>
<td><strong>25.8</strong></td>
</tr>
<tr>
<td>Eastern Metropolitan</td>
<td>47</td>
<td>23.9</td>
</tr>
<tr>
<td>Northern Metropolitan</td>
<td>27</td>
<td>13.7</td>
</tr>
<tr>
<td>Western Metropolitan</td>
<td>42</td>
<td>21.3</td>
</tr>
<tr>
<td>Southern Metropolitan</td>
<td>30</td>
<td>15.2</td>
</tr>
<tr>
<td><strong>Sub-total metropolitan regions</strong></td>
<td><strong>146</strong></td>
<td><strong>74.1</strong></td>
</tr>
<tr>
<td>Total</td>
<td>197</td>
<td>100</td>
</tr>
</tbody>
</table>

Note. For the General Secure Welfare Service, North and Western are a combined figure.

There were 197 admissions of young people in the Secure Welfare Service who were clients of Take Two, representing 21 percent of all admissions to the Secure Welfare Service in 2004 and 2005. There was minimal change in this pattern across the two years. The 197 Take Two Secure Welfare referrals in 2004 and 2005 related to 156 young people. In terms of the percentage of young people admitted to the Secure Welfare Service who were clients of Take Two, this increased slightly from 38 percent in 2004 to 41 percent in 2005. In other words, although Take Two Secure Welfare worked with a fifth of the Secure Welfare Service admissions, this represented two fifths of the number of young people.

Forty-four young people were seen by Take Two Secure Welfare on two or more occasions, with the highest being one young woman who was seen by Take Two during five of her ten admissions to the Secure Welfare Service in one year. Some of these admissions were months apart, while others occurred within weeks. Two admissions involving Take Two were within a matter of days of the young woman being discharged from the Secure Welfare Service. These reflect a common pattern of usage within the Secure Welfare Service of frequent admissions for some young people as part of the crisis management process whilst others only have one or two admissions. As seen in Table 14, nearly a quarter of the young people had four or more admissions into the Secure Welfare Service however, Take Two was not necessarily involved in every admission. Although Take Two did not automatically see every young person upon re-admission, examples of situations which were re-referred were when Take Two was asked to re-assess or to continue to try to engage with the young person and, as such, to work with those responsible for their care and case management.
Table 14
**Number of Admissions to the Secure Welfare Service for Secure Welfare Take Two Clients in 2004 and 2005**

<table>
<thead>
<tr>
<th>Number of admissions to Secure Welfare Service in year of Take Two involvement</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>35</td>
<td>46.7</td>
</tr>
<tr>
<td>2</td>
<td>16</td>
<td>21.3</td>
</tr>
<tr>
<td>3</td>
<td>10</td>
<td>13.3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>6.7</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
<td>2.7</td>
</tr>
<tr>
<td>6</td>
<td>3</td>
<td>4.0</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>2.7</td>
</tr>
<tr>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10+</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>75</td>
<td>100</td>
</tr>
</tbody>
</table>

**2005**

<table>
<thead>
<tr>
<th>Number of admissions to Secure Welfare Service in year of Take Two involvement</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>25</td>
<td>29.8</td>
</tr>
<tr>
<td>2</td>
<td>20</td>
<td>23.8</td>
</tr>
<tr>
<td>3</td>
<td>14</td>
<td>16.7</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>6.0</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td>3.6</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
<td>6.0</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>8</td>
<td>4</td>
<td>4.8</td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>10+</td>
<td>6</td>
<td>7.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>84</td>
<td>100</td>
</tr>
</tbody>
</table>

**Missing data**

| Overall Total | 85  |

**Note.** Number of admissions to Secure Welfare Service was only available for the year the young person was referred to Take Two Secure Welfare.
Table 15 shows the number of days Take Two clients were placed in the Secure Welfare Service over cumulative admissions. In terms of length of time in the Secure Welfare Service, the mean length of stay per admission for those young people involved with Take Two was nine days (SD = 10.5). This is similar to the average length of stay for young people in the Secure Welfare Service in general, which in 2005 was nine days. Although 49 percent of the young people were admitted to the Secure Welfare Service for a cumulative period of less than 20 days in one year, 16 percent were in the Secure Welfare Service for a total of 50 days or longer within a year, as calculated over a number of admissions.

### Table 15

**Total Days Placed in the Secure Welfare Service for Secure Welfare Take Two Clients in 2004 and 2005**

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of days in Secure Welfare Service</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>0 to 9</td>
<td>20</td>
<td>26.7</td>
</tr>
<tr>
<td>10 to 19</td>
<td>20</td>
<td>26.7</td>
</tr>
<tr>
<td>20 to 29</td>
<td>10</td>
<td>13.3</td>
</tr>
<tr>
<td>30 to 39</td>
<td>7</td>
<td>9.3</td>
</tr>
<tr>
<td>40 to 49</td>
<td>7</td>
<td>9.3</td>
</tr>
<tr>
<td>50 to 59</td>
<td>5</td>
<td>6.7</td>
</tr>
<tr>
<td>60 to 69</td>
<td>2</td>
<td>2.7</td>
</tr>
<tr>
<td>70+</td>
<td>4</td>
<td>5.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>75</td>
<td>100</td>
</tr>
</tbody>
</table>

**Note.** Number of days in Secure Welfare Service was only available for the year the young person was referred to Take Two Secure Welfare.

### 4.6 Child’s experience of abuse and neglect

#### 4.6.1 Experiences of abuse and neglect prior to referral to Take Two

Analysis of the data from the Harm Consequences Assessment completed by referrers in 2004 and 2005 reveal the types of abuse and neglect the children were known to have experienced. These classifications relate to the legislation’s classification of what constitutes children being in need of protection (*Children and Young Persons Act 1989*, s.63; *Children, Youth and Families Act 2005*, s.162).

As shown in Figure 12, nearly all children referred to Take Two have suffered emotional and psychological abuse (97%). Examples include verbal abuse, threats to cause harm, constant emotional unavailability, absence of affection, exposure to family violence and exposure to parental substance abuse. A large majority have suffered abandonment or inadequate parenting (84%), such as abandonment with no appropriate alternate carer, multiple placements and lack of supervision. A large majority of the children had experienced some form of physical abuse (83%), such as being hit, punched or burnt. Developmental and medical abuse was reported for 62 percent of clients. Many examples of this type of maltreatment can be classified as neglect, such as inadequate stimulation, inadequate medical care, lack of food or fluids and not sending the child to school. Sexual abuse was the least frequently reported, but still noted for 41 percent of the children referred to Take Two.
Although much of the developmental abuse category pertains to neglect, certain items in other categories also relate to neglect, such as in the abandonment and emotional abuse categories. Further analysis of the Harm Consequences Assessment was therefore undertaken to provide more detailed information regarding children's experience of neglect. Items pertaining to neglect were recoded with the finding that 98 percent of the children who were clients of Take Two in 2004 and 2005 experienced some form of neglect prior to referral to Take Two. The most frequent neglect-related items recorded were:

- chaotic family lifestyle (60%);
- emotional unavailability of parent figures (57%);
- failure to ensure safety (45%);
- inadequate caring relationships (45%);
- lack of boundaries (38%);
- frequent failure to ensure safety (30%);
- parental incapacity such that they cannot care for the child and there is no other appropriate carer (30%);
- pattern of extreme rejection (28%);
- lack of discipline (28%);
- inadequate basic care (25%);
- continuous inadequate supervision (24%); and
- extreme lack of supervision (21%).

As seen from these data, many of the children suffered from patterns of repetitive failures to meet their emotional needs and placing them at risk from other dangers. There were also examples of children suffering from physical neglect such as inadequate medical care (16%); continuous inadequate provision of food or fluids (9%); and inadequate clothing (8%). Examples of developmental neglect included inconsistently sending the child to school (17%); inadequate stimulation (15%) and absence of stimulation (9%).

Figure 13 provides examples of some of the experiences suffered by Take Two clients that relate to parental difficulties such as substance abuse, family violence and parental mental illness. Forcing a child to witness violence is an explicit action undertaken by a violent parent, compared to a child who is inadvertently exposed to family violence. An example of such an action is the child whose father drags her into the room and says 'watch what I do to your mother'. Both are harmful, but the forcing of the child has an added degree of severity and intent.

As seen in Figure 13, younger children were more likely to have been exposed to family violence and parental psychiatric illness. Younger children and adolescents were significantly less likely to be forced to witness violence ($X^2(2) = 12.36, p < .01$). Adolescents were significantly less likely to have been born drug dependent ($X^2(1) = 6.31, p < .05$); exposed to family violence ($X^2(2) = 25.88, p < .001$); or exposed to parental psychiatric illness ($X^2(2) = 11.02, p < .01$). The only item in this figure which showed no statistically significant difference by age was exposure to parental substance abuse. These distinctions by age are notable given that the aim of the Harm Consequences Assessment is to collect cumulative information over the child's life, not just current issues. One hypothesis is that when children are older, the system focuses more on their behavioural presentation and on the harmful experiences they are dealing with currently than on their previous life experience or from a cumulative harm perspective. This may also be influenced by the recency of some of these issues. For example, being born drug dependent is a more recent issue for young children than adolescents.

Children who were born drug dependent were significantly more likely to be from a metropolitan area compared to a rural area ($X^2(1) = 4.56, p < .05$) but there were no significant differences by Aboriginal identity or gender. Aboriginal children were more likely to be exposed to parental substance abuse than non-Aboriginal children ($X^2(1) = 6.69, p < .01$). Similarly, Aboriginal children were more likely to be forced into a situation where they witnessed violence ($X^2(2) = 5.00, p < .05$).

Take Two Secure Welfare clients were significantly less likely to have been exposed to parental substance abuse ($X^2(1) = 5.83, p < .01$); significantly less likely to be exposed to parental psychiatric illness ($X^2(2) = 7.18, p < .05$) and significantly less likely to be forced to witness ($X^2(1) = 5.28, p < .05$) or otherwise exposed to family violence ($X^2(1) = 39.91, p < .001$). Again, this may be the young people's different experience, or may be a factor of their case worker's perception of what are the sources of harm.
Figure 14 shows that 96 percent of the children involved with Take Two over 2004 and 2005 had experienced two or more types of abuse and neglect. Nearly two thirds (63%) had suffered four or five types of maltreatment. This illustrates the reality for many of these children of multiple traumas and experiences of deprivation.

4.6.2 Experiences of abuse and neglect and/or trauma since Take Two involvement

Take Two was asked by DHS to record whether or not children had experienced further abuse or neglect during Take Two’s involvement. This was undertaken in the context of the State Government’s strengthened policy and programmatic approaches to increasing the quality of out-of-home care and to provide for the safety and wellbeing of children in their care. It also reflects one of the primary aims within the Take Two framework which is to promote the safety of children. It provides an important context for understanding the experiences of these children and their exposure to trauma, in addition to the circumstances that led to their initial involvement with Child Protection.

Take Two clinicians were asked via the survey to describe whether or not any of the children involved with Take Two during 2005 (not including Secure Welfare) had experienced new incidents of maltreatment. This included children who had been referred in 2004 or 2005, as long as the case was still open during 2005. Following analysis of these results, it was evident that some clinicians had also included other traumatic or distressing incidents that were not specifically related to maltreatment. A conservative approach was taken to the analysis and so these incidents were not included.
As shown in Table 16, according to Take Two staff new incidents of abuse or neglect occurred for nearly a third of the 352 children involved with Take Two during 2005 (n = 113; 32%). Twenty-six children (7%) experienced more than one such abuse or neglect event during Take Two’s involvement. In addition, according to Take Two, another 17 children had an incident investigated by Child Protection during Take Two involvement, but not substantiated. These unsubstantiated concerns were not included in this analysis.

The majority of these incidents (57%) were by family members, predominantly parents or step-parents. Other incidents reflect abuse in care, either by carers (13%) or other children living in the placement (4%). Although the type of placement was not always clear, concerns of abuse were noted by Take Two clinicians, mainly for children in foster care, followed by kinship care then residential care. Another six children (5%) experienced abuse from both family members and carers during Take Two involvement. In other words, 22 percent of children suffered abuse while in out-of-home care. Another 15 children (13%) suffered abuse where it was not specified if it was by family members or carers. Regardless of who was the source of harm, these data provide a background for understanding the choices of therapeutic interventions and the barriers for positive outcomes for a number of these children.

For the purposes of this analysis, the incidents described by Take Two clinicians were classified by the research team into the same headings as used in the Take Two Harm Consequences Assessment document. Severity of abuse was not measured, although some anecdotal responses indicated a range from concerning through to extremely serious. Examples of abuse listed included severe assault while on access; emotional abuse; abandonment; being physically injured due to abuse; being kicked; exposed to severe family violence; exposed to parent’s mental illness such as paranoia and erratic presentation; neglect, including the home becoming uninhabitable and lack of food; being locked in a room all day; being locked up at night; verbal abuse; exposed to parent’s substance abuse; inappropriate physical discipline; overt rejection; supplied drugs by adult family members; exposure to sexualised behaviours in others and sexual abuse. Take Two clinicians were sometimes the informant to Child Protection regarding these situations of risk and at other times were informed by Child Protection or other services of the concerns.

A type of abuse that showed some difference by source of harm was sexual abuse. Of the 13 cases where the perpetrator was recorded, 6 of the sexual assaults were by people outside the family or care environment. The other difference noted was in relation to developmental harm. This was predominantly in relation to neglect and almost always related to the behaviour or absence of behaviour from the child’s parents.

| Table 16 |
| Incidence of Abuse or Neglect during Take Two Involvement for Open Cases in 2005, not including Secure Welfare, according to Take Two Clinicians (N = 352) |

<table>
<thead>
<tr>
<th>Abuse and neglect incidents since Take Two involvement</th>
<th>N of cases</th>
<th>% of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>No new incident of abuse/neglect known to Take Two</td>
<td>239</td>
<td>67.9</td>
</tr>
<tr>
<td>New incident of abuse/neglect known to Take Two</td>
<td>113</td>
<td>32.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Source of harm relating to abuse and neglect</th>
<th>N of cases</th>
<th>% of cases where incident reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family member</td>
<td>64</td>
<td>56.6</td>
</tr>
<tr>
<td>Carer</td>
<td>15</td>
<td>13.3</td>
</tr>
<tr>
<td>Others in placement</td>
<td>4</td>
<td>3.5</td>
</tr>
<tr>
<td>Carer and family members (separate incidents)</td>
<td>6</td>
<td>5.3</td>
</tr>
<tr>
<td>Others, e.g. friends, strangers</td>
<td>9</td>
<td>8.0</td>
</tr>
<tr>
<td>Source of harm not specified</td>
<td>15</td>
<td>13.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of incident, classified according to Harm Consequences Assessment</th>
<th>N of incidents</th>
<th>% of incidents where incident reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abandonment/no appropriate carer</td>
<td>3</td>
<td>1.9</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>41</td>
<td>26.5</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>15</td>
<td>9.7</td>
</tr>
<tr>
<td>Emotional and psychological abuse</td>
<td>91</td>
<td>58.7</td>
</tr>
<tr>
<td>Developmental abuse</td>
<td>22</td>
<td>14.2</td>
</tr>
</tbody>
</table>

Incidents of abuse were reported by Take Two clinicians for significantly more infants and significantly fewer adolescents ($X^2(5) = 17.15, p < .01$). In fact 50 percent of the children under the age of three had some reported form of maltreatment occur during Take Two involvement and 38 percent of children aged between three and six years. This finding is of significant concern particularly given the heightened vulnerability of infants and preschoolers. It is
also noteworthy given the relatively low numbers of referrals of infants to Take Two. The age group with the smallest percentage of reported further abuse was young people aged 15 years or older. New incidents of abuse reportedly occurred for significantly more children in metropolitan compared to rural areas ($X^2(1) = 21.06, p < .001$).

As seen in Table 16, emotional and psychological harm was the major form of abuse of children during Take Two involvement, accounting for 59 percent of incidents of abuse. Physical harm and injury also accounted for a substantial proportion of incidents of abuse (27%).

Physical harm or injury and emotional harm were reported for significantly more metropolitan than rural clients ($X^2(1) = 8.10, p < .01$ and $X^2(1) = 13.70, p < .001$ respectively). Emotional abuse was noted as occurring more often for infants than older children ($X^2(5) = 14.22, p < .05$). In terms of the different types of maltreatment there were no significant differences on the basis of placement at time of referral, Aboriginal identity or gender. More boys than girls were reported as experiencing sexual abuse (seven compared to three).

Action taken by Take Two or Child Protection was not always recorded. However, on at least nine occasions new notifications were made to Child Protection, primarily by Take Two. In nine situations the children were removed from their placement or home. On another three occasions the police were involved and on another three occasions access arrangements were changed. Two children were hospitalised as a result of the abuse.

4.7 The consequences of abuse and neglect

4.7.1 Overview of consequences of abuse and neglect

There are multiple consequences to children of their experience of abuse and neglect, as shown in Figure 15. Overall, 95 percent of children involved with Take Two in 2004 and 2005 were described at referral as having two or more domains of concern, and 81 percent were found to have three or more areas of concern.

As found in the previous evaluation (Frederico, Jackson, & Black, 2005), the most frequently noted difficulties were emotional (95%), followed by concerns regarding the child’s sense of abandonment and lack of connection with others (87%), then developmental harms relating to their health and developmental milestones (74%). Concerns relating to physical health or injury (48%) and sexual health and related harms (41%) were also noted.

Figure 16 provides examples of emotional and behavioural consequences that highlight the difficulties experienced by many of the children and those who care for them. As expected, many of these difficulties are more likely to be seen with adolescents, but it is alarming to see that they are also present for a number of primary school-age children. The rate of repeated and severe violence towards others (83%) by young people is of particular concern.

Figure 15. Number of types of consequences of maltreatment according to the Harm Consequences Assessment prior to referral for all Take Two clients in 2004 and 2005 (N = 555)
4.7.2 Sexualised behaviours

Further analysis of some of these serious behavioural concerns was undertaken. Twenty percent of children \( (n = 112) \) were described at time of referral as having one or more sexualised behaviours. This was calculated so that where more than one sexualised behaviour was listed, this analysis only includes the most severe presentation. These behaviours included sexual violence towards others, patterns of inappropriate sexualised behaviours towards others and sexual harassment.

In relation to sexualised violence towards others, although the significant majority were aged 12 years or older, six children \( (9\%) \) were aged between 6 and 12 years \( (X^2(2) = 6.73, p < .05) \). When adding the children with those who showed a pattern of sexualised behaviours the age difference was still significant; however, another 21 children aged younger than 12 years also exhibited these behaviours \( (X^2(2) = 9.02, p < .05) \). There was no significant age difference amongst children who were reported as sexually harassing other children.

In terms of gender differences, males were significantly more likely to be described as showing sexualised violence towards others \( (X^2(1) = 5.21, p < .05) \). However, in relation to patterns of inappropriate sexualised behaviours towards others, there was no significant gender difference. The largest difference was found in relation to sexual harassment, with males showing more of this behaviour than females \( (X^2(1) = 11.82, p < .01) \).

There was no significant difference regarding sexualised violence or sexual harassment between Aboriginal and non-Aboriginal children. However, non-Aboriginal children were significantly more likely to show patterns of inappropriate sexualised behaviours towards others than Aboriginal children \( (X^2(1) = 4.91, p < .05) \).

The numbers of children from rural areas showing sexualised violence were slightly higher than those from metropolitan areas. This indicates a significant disproportionally high number of children from rural areas, given their generally lower numbers within Take Two \( (X^2(1) = 5.23, p < .05) \). There were no significant metropolitan or rural differences noted in relation to the other sexualised behaviour categories. In terms of the Take Two Secure Welfare population compared to the other Take Two clients, the only significant difference was in relation to patterns of inappropriate sexualised behaviours. Secure Welfare clients were significantly more likely to show these types of difficulties \( (X^2(1) = 9.63, p < .01) \).

4.7.3 Suicidal presentation

Suicidal ideation and attempts were also closely analysed. Twenty percent of children \( (n = 109) \) had made either an attempt at suicide and/or exhibited suicidal ideation prior to referral to Take Two.

All except two of the 37 children who had attempted suicide were aged 12 years or older \( (X^2(2) = 25.82, p < .001) \). The number of children under the age of 12 years who showed suicidal ideation was higher \( (n=16) \), although children 12 years and older were significantly more likely to show such behaviours \( (X^2(2) = 21.43, p < .001) \). Females were significantly more likely to either attempt suicide \( (X^2(1) = 15.94, p < .001) \) or to demonstrate suicidal ideation \( (X^2(1) = 8.29, p < .01) \).

There were no significant differences between Aboriginal or non-Aboriginal children in either suicide attempts or suicidal ideation. However, it was close to being significant that Aboriginal children were more likely to have suicidal ideation \( (X^2(1) = 3.86, p = .05) \). There were no significant differences in any suicidal presentation and whether the children lived in metropolitan or rural areas. Children in Secure Welfare were significantly more likely to have attempted suicide \( (X^2(1) = 21.64, p < .001) \) and to show suicidal ideation \( (X^2(1) = 11.01, p < .01) \).

4.7.4 Mental health diagnoses

Diagnosis is a mental health approach, where individuals are assessed in terms of criteria within the DSM-IV (APA, 1994) to determine whether or not they have the requisite number and intensity of symptoms that indicate certain psychological impairments. Mental health diagnosis is not a
prerequisite for Take Two involvement; however, Table 17 shows the high numbers who meet the criteria for one or more mental health diagnoses.

The majority of children involved with Take Two over the first two years of operation (62%) met the criteria for at least one mental health diagnosis as described in the DSM-IV. Sixty children (18%) met the criteria for two diagnoses and 14 children (4%) met the criteria for three diagnoses. There were 30 children for whom the assessment was not complete and 17 for whom the information was not available. There has been no change in this rate of mental health disorders within the Take Two client group over the two years. This continues to support the findings elsewhere regarding the mental health needs of children in the protection and care system (e.g. Cicchetti & Lynch, 1995; Arcelus, Bellerby, & Vostanis, 1999; Lindsey, 2000; Milburn, 2004; Tarren-Sweeney & Hazell, 2006). Tarren-Sweeney and Hazell (2006) highlight the connection between poor mental health for children and their exposure to early maltreatment and disrupted attachments.

Children aged 12 years and older were significantly more likely to have a mental health diagnosis than children aged less than six years (70% of 12-<18 years compared to 45% of 0-<6 years; \(X^2(2) = 11.68, p < .01\)). Males were significantly more likely to have a mental health diagnosis than females (69% of males compared to 49% of females; \(X^2(1) = 13.29, p < .001\)). There was no significant difference in the rate of mental health diagnosis in relation to Aboriginal identity or whether the child lived in a metropolitan or rural area. It is worth noting that the Aboriginal team within Take Two is exploring the application of diagnosis within a holistic culturally informed understanding of health and so rarely formulates a diagnosis at this time.

Reactive Attachment Disorder and Posttraumatic Stress Disorder were the most frequently diagnosed disorders within Take Two and were major indicators of relational trauma experienced by many of these children. Although acknowledging the high proportion of mental health concerns within this population, some authors note that many children who have suffered mental distress as a result of trauma and deprivation may not meet the full criteria of particular disorders such as Posttraumatic Stress Disorder. This is seen as being influenced by this and most other disorders being originally developed for adults and so the symptom descriptions do not always fit with childhood presentations (Perry, 1999). Traumatised children are, however, likely to experience a number of the symptoms, while not always meeting the full diagnostic criteria. There were no significant differences in the diagnosis of Reactive Attachment Disorder or Posttraumatic Stress Disorder among the different age groups, by gender, Aboriginal identity or metropolitan versus rural location.

### Table 17
Mental Health Diagnoses according to Take Two Clinicians for Take Two Clients, not including Secure Welfare, for 2004 and 2005

<table>
<thead>
<tr>
<th>Mental health diagnoses</th>
<th>N of responses</th>
<th>% of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reactive Attachment Disorder</td>
<td>80</td>
<td>23.5</td>
</tr>
<tr>
<td>Posttraumatic Stress Disorder/Complex PTSD</td>
<td>54</td>
<td>15.9</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>42</td>
<td>12.3</td>
</tr>
<tr>
<td>Oppositional Defiance Disorder</td>
<td>22</td>
<td>6.5</td>
</tr>
<tr>
<td>Attention-Deficit/Hyperactivity Disorder</td>
<td>21</td>
<td>6.2</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>18</td>
<td>5.3</td>
</tr>
<tr>
<td>Anxiety Disorders (excluding PTSD)</td>
<td>13</td>
<td>3.8</td>
</tr>
<tr>
<td>Adjustment Disorders</td>
<td>16</td>
<td>4.7</td>
</tr>
<tr>
<td>Communication Disorders</td>
<td>8</td>
<td>2.3</td>
</tr>
<tr>
<td>Other disorders</td>
<td>11</td>
<td>3.3</td>
</tr>
<tr>
<td>No diagnosis</td>
<td>130</td>
<td>38.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>344</strong></td>
<td></td>
</tr>
</tbody>
</table>

### 4.7.5 School involvement

Table 18 shows that, according to the Child Protection records (Client Profile Document), the majority of school-age children were enrolled in a school at the time of referral to Take Two. Most of the children not attending school were 15 years or older. Most of the missing data for this item related to Secure Welfare clients.
As found in the previous evaluation report (Frederico, Jackson, & Black, 2005), school enrolment and school attendance are not the same. The data provided at time of referral via the Harm Consequences Assessment show that 223 children (38%) had issues regarding school attendance, most of which (n = 184; 32% of total) were described as a serious lack of or no school attendance. One hundred and nine (19%) children aged between 6 and 15 years had serious school attendance problems. Another two children were under the age of 6 years and 74 (13%) were young people aged 15 years or older.

4.7.6 Speech, language and hearing development and functioning

In providing more detailed analysis of the children’s development, a partnership was formed with the School of Human Communication Sciences, La Trobe University and began with a detailed focus on speech, language and hearing development. This was largely influenced by the understanding that a child’s ability to communicate with others and to learn is at direct risk if subjected to sustained trauma and deprivation. Although there has been minimal systematic research into the speech and language deficits of children who have suffered abuse, there is some literature relating to the impact of neglect and deprivation.

Children suffering severe neglect may have been inadequately stimulated and insufficiently exposed to speech and comprehension activity. Children living in violent and chaotic home environments may have been explicitly or implicitly discouraged or even forbidden to speak. As speech and language is use-dependent, if children are insufficiently stimulated it is likely that the relevant areas of the brain responsible for these functions will be limited in their development (Grant & Gravestock, 2003).

Lynch and Roberts (1982) observed two groups of physically abused children who demonstrated speech delay; those who were silent and under-achieving in all areas (referred to by Ounsted, Oppenheimer, & Lindsay, 1974, as ‘frozen watchfulness’) and children who were agile and socially competent but silent. These language delays continued to be evident in their follow-up study. The delays were demonstrated by minimal spontaneous chatter and a lack of questioning even whilst playing.

Some of the children’s language delay was disguised by the development of limited speech designed specifically to please adults. It had the quality of ‘cocktail party’ conversation, full of acceptable ‘situational phrases’. We often found that the parents, too, were relatively inarticulate and there was a marked lack of verbal communication in the home. (Lynch & Roberts, 1982, p.94)

Coster and Cicchetti (1993) found that maltreated toddlers were lower on all measures of expressive vocabulary as well as on total number of different words used compared to non-maltreated children. These children talked less about their own activities and made fewer references to persons or events outside their immediate situation (Cicchetti, Toth, & Bush, 1988). Another study also found that maltreated young children lagged significantly in the use of internal-state words about their self and other people compared to non-maltreated children (Cicchetti, Toth, & Bush, 1988).

Cicchetti and colleagues posit that maltreated children may use fewer internal-state words due to parental disapproval of expressing certain affects. They may therefore be over-controlled in order to meet their parents’ expectations. Alternatively, their parents may not be able to decode their emotional signals and may mislabel certain behaviours.

The confounding issue with language development and communication is that although a child’s ability to effectively communicate may be impaired as a result of maltreatment, communication is an essential resource to assist recovery from trauma, the building of relationships and to facilitate the child’s capacity to learn.

When a person cannot directly express or speak of their trauma, either because they were too young to have a language or frame of reference for their experience or because repression, threats or an adult’s refusal to ‘hear’ has silenced them, no verbal link can exist between dissociated parts. Without any way of verbally representing the trauma, they might find other ways of communicating the separate experiences of these split-off parts in order for all parts to survive. So the body may speak a language of its own, perhaps through illness, pain, compulsion or addiction. (Etherington, 2003, p.29)

Language is a key developmental task of childhood. The importance of speech and language in children’s overall wellbeing cannot be underestimated.

Language is fundamental in the establishment of a sense of self as separate from others, and allows the child to make sense of the world around them (Halliday, 1975). Its appropriate development is therefore critical in the establishment of identity, and in the fostering of attachment relationships. (Grant & Gravestock, 2003, p.5)

As a result of these and other findings, a draft speech and language screening tool was developed by Associate Professor Anne Ozanne (School of Human Communications

<table>
<thead>
<tr>
<th>School Enrolment</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child not attending school</td>
<td>87</td>
<td>20.3</td>
</tr>
<tr>
<td>Primary School</td>
<td>173</td>
<td>40.3</td>
</tr>
<tr>
<td>Secondary School</td>
<td>98</td>
<td>22.8</td>
</tr>
<tr>
<td>Alternative School</td>
<td>62</td>
<td>14.5</td>
</tr>
<tr>
<td>TAFE</td>
<td>9</td>
<td>2.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>429</td>
<td>100</td>
</tr>
<tr>
<td>Missing data</td>
<td>84</td>
<td></td>
</tr>
</tbody>
</table>

Table 18
Enrolment in School at Time of Referral for Take Two Clients aged six years and older in 2004 and 2005

The tool was completed for a sample of 108 children from all nine regional teams, ranging from 5 to 22 clients per team. The largest completion rates for the draft screening tool were from the Eastern team (20%), followed by Western (18%), Gippsland (13%) and Grampians (12%). The Secure Welfare and Aboriginal teams did not participate in this pilot study.

These 108 cases were approximately 50 percent of all Take Two client cases open during the data collection time period (mid-February to mid-March, 2005). Sixty-nine percent of this sample were male, which is slightly higher than the ratio of male to female clients among the regional Take Two client group more broadly. The youngest child in the sample was aged 3 years and the oldest was 17 years. The majority of children (52%) were aged 9 to 15 years, similar to the Take Two client group as a whole. Nine percent of the sample was Aboriginal, which is less than the proportion in the general Take Two client group.

One or more of the 24 questions on the draft speech and language screening tool were ticked ‘Yes’ in 89 tools (82%). This indicated the need for further consultation and possible need for speech and language assessment. In taking a more conservative estimate, two or more questions were ticked ‘Yes’ in 74 tools (69%). Children aged between 12 and 15 were more likely to have two items ticked (83% of this age group), with the next highest group being children aged between 6 and 9 (71% of that age group). However, this difference was not significant. It was acknowledged, however, that the tool required further adaptation to sufficiently pick up language and communication issues for infants.

As a point of comparison, 92 children (16%) referred to Take Two in 2004 and 2005 had speech or language problems identified by the referrer via the Harm Consequences Assessment. This may indicate that some of the indicators of speech and language are not readily apparent and as such highlights the value of screening. These children with reported difficulties in the Harm Consequences Assessment were from across all age groups, with the highest being in the three- to six-year range (n = 24) and the lowest being less than three years (n = 10).

In the draft screening tool, boys were more likely to be identified with two or more speech or language concerns than girls (74% of boys and 56% of girls). This is consistent with findings in the general population regarding the higher prevalence of speech difficulties for boys (Petheram & Enderby, 2001; Keating, Turrell, & Ozanne, 2001).

There was a high proportion of missing data on some of these items, probably due to items not being applicable for some children or information not being known. Table 19 provides a description of some of the items in the draft speech and language screening tool for school-age children.

<table>
<thead>
<tr>
<th>Examples of hearing, speech and language concerns</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible hearing difficulties</td>
<td>6</td>
<td>63</td>
<td>20</td>
</tr>
<tr>
<td>Make any errors in sound after 6 years (except “th” and “r”)</td>
<td>20</td>
<td>54</td>
<td>19</td>
</tr>
<tr>
<td>Children who use very short sentences</td>
<td>22</td>
<td>58</td>
<td>14</td>
</tr>
<tr>
<td>Children who appear to have trouble finding the word they want</td>
<td>35</td>
<td>41</td>
<td>12</td>
</tr>
<tr>
<td>Children who have difficulty putting their thoughts into words</td>
<td>45</td>
<td>39</td>
<td>9</td>
</tr>
<tr>
<td>Children who lack social skills</td>
<td>52</td>
<td>34</td>
<td>7</td>
</tr>
<tr>
<td>Children who have difficulty sustaining a conversation or a coherent line of thought</td>
<td>44</td>
<td>40</td>
<td>8</td>
</tr>
<tr>
<td>Children who can not retell a non-traumatic incident or story or where story does not follow a logical line</td>
<td>27</td>
<td>51</td>
<td>15</td>
</tr>
<tr>
<td>Children having literacy problems</td>
<td>46</td>
<td>30</td>
<td>15</td>
</tr>
<tr>
<td>Children who do not appear to understand what is being said to them</td>
<td>21</td>
<td>65</td>
<td>7</td>
</tr>
</tbody>
</table>
A high proportion of children were considered to have possible difficulties regarding their expressive and/or receptive language development. Examples of hearing problems included partial or total deafness and a perforated ear drum. Four children had been previously diagnosed with a significant speech disorder, including a language-based learning disorder and severe expressive and receptive language disorders. As illustrated in Table 19, obvious speech problems such as stuttering are not the only indicators of speech and language problems. Poor literacy, eating problems, social problems and difficulties in telling stories are examples of other problems that can indicate the need for speech and language assessment. As discussed earlier, speech and language problems can also be an indicator of other concerns, such as exposure to abuse or neglect. This again emphasises the need for assessment. These examples demonstrate the importance of speech and language development for children in terms of their social development, identity and ability to engage in therapy. For example children who find it difficult to sustain a conversation, tell a non-traumatic story or understand what is being said to them will find most verbal therapeutic approaches very difficult or inaccessible.

In terms of outcomes from these previous speech and language assessments, at the time of the survey at least two children were receiving speech therapy, two children have been on waiting lists for speech therapy for over a year, and outcomes of assessment for another two children were pending. Other examples of specific strategies included an operation on the child's mouth, integration support at school and funding for private speech therapy. Practical suggestions and guidance by Take Two clinicians were also provided to schools, parents and carers regarding how best to communicate with the children.

These preliminary findings illustrate the need for speech and language assessment, and in many cases intervention, for children who have experienced abuse or neglect. Children with persistent speech and language problems should be assessed as early as possible for optimal outcomes, as language delay is a key risk factor for later literacy difficulties (Larney, 2002; Poe, Burchinal, & Roberts, 2004). Furthermore, if not diagnosed, communication disorders can lead to later behavioural problems (Lindsay & Dockrell, 2000).

Therapeutic programs for abused children have typically not included speech therapy or intensive language stimulation; rather, they have generally focused on emotional issues, apparently on the assumption that with the resolution of these the language will spontaneously improve. (Allen & Oliver, 1982, p. 305)

4.8 Summary

In Take Two's second year of operation, many of the findings identified in its first year continue to be evident. In particular, the referral patterns remain focused on older children and on children who present with severe to extreme emotional and behavioural problems. Although children with such difficulties should be a major proportion of the Take Two client group, there remains a concern that the referral patterns do not reflect the full charter for Take Two which includes work with children who have experienced trauma but are not yet showing such difficulties. Another form of early intervention that has not been sufficiently utilised is for Take Two to work with infants and younger children. The small number of referrals for young children is in contrast to the proportion of this age group represented in the general Child Protection client group and in contrast with the growing evidence of the need to intervene with children in the first three years of life.

Another finding has been the growing disproportionate numbers of Aboriginal children referred to Take Two. This indicates both a concern regarding the vulnerability and likelihood of risk for Aboriginal children as well as the importance of such a service being available to respond to their needs. It highlights the need for Take Two to work closely with Aboriginal organisations such as VACCA, the Victorian Aboriginal Health Service and local community co-operatives.

The number of children who have continued to experience further abuse, neglect and other traumatic events after Child Protection, out-of-home care and Take Two are involved is very concerning. In addition to highlighting the complexity of the roles of all services in these children's lives to keep them safe and to help them to 'feel' and experience safety, it reinforces the ongoing pattern of trauma and deprivation that many of these children continue to experience. These results indicate that Take Two clients, particularly infants, cannot be assumed to be safe from abuse, trauma or further distress during therapeutic intervention. This raises questions about how to approach therapeutic intervention until the children's safety can be assured and what are reasonable outcomes to expect until this occurs. This issue requires that major emphasis must be placed on working collaboratively with all those working with the child.

The ramifications of abuse, neglect and other related trauma and deprivation in these children's lives include developmental, emotional and behavioural consequences. These behaviours include violence, sexualised behaviours and suicidal ideation for many of these children. This chapter has focused on the impact of trauma on children's speech, language and hearing development and the increasing problems if the child is not able to communicate effectively. Chapter 6 which explores the children's social networks will also highlight the social impact.

The continued high demand for Take Two's role within the Secure Welfare Service is evident. The high regard in which the Take Two Secure Welfare role is held will be described in Chapter 10. With the expansion of this role in late 2006 it will be important to continue to monitor the demand provided by Take Two within the unique setting of the Secure Welfare Service.

The description of the children's experiences of abuse and deprivation, both before and in some situations during their involvement with the child protection and care system, provides an important context for understanding the next chapter regarding interventions and subsequent chapters relating to outcomes. For example, the isolation of many of these children from their siblings is a theme that is picked up strongly through the Social Network Maps that the children complete within Take Two. A qualitative analysis of a sample of these children's life experiences is explored in Chapter 6 of this report.
Chapter 5: Interventions - How did Take Two and other services intervene with these children and young people?

5.1 Overview

This chapter describes the interventions utilised by Take Two staff during the two-year period 2004-2005. Most of the data reported in this chapter were obtained from a survey completed by all clinicians in the regional and Aboriginal teams regarding cases open in 2005. Data were also obtained from staff journals. These data have been augmented by analysis of the Take Two staff’s client activity sheets and referral documents.

The challenge in portraying the complexity of interventions is epitomised by the frequently posed question of ‘what is in the black box?’ During Take Two’s pre-operational stage in 2003 there was a constructive debate within the Take Two consortium and beyond regarding whether one or two approaches should be the cornerstone of intervention or whether a broader canvas of interventions based on rigorous assessment and formulation was appropriate. It was decided that the initial Take Two Practice Framework would establish practice principles and list the range of therapeutic approaches possible. It emphasised the function of assessment and formulation in making the choice of intervention. This was largely influenced by the view that the nature of the client group was complex, as were the goals of working towards recovery from chronic abuse and neglect. In addition, there was a dearth of knowledge regarding what interventions actually work best with children with these multi-faceted problems.

As mentioned in Chapter 3, there has been extensive work on the development of the Practice Framework to assist the determination of the most fitting approach for each child within his or her developmental, relational and ecological context. Beginning with the desired outcomes as described in the referral documentation, Take Two determines through assessment whether the focus of intervention will begin with the child and/or the child’s immediate relationships and/or the broader system. In most cases there is a rich combination of interventions focused on working towards recovery and reconnection of relationships. When unsuccessful or deemed unlikely to be successful in directly engaging the child, Take Two often strives to work in other ways and with other aspects of the child’s context, whilst continuing to work towards seeing the child directly. The flexibility and creativity implied in this approach is believed to be a core factor in the greater than 95 percent level of engagement of the children, their family, placement and/or the system in working towards the desired outcomes. In other cases, the requested role for Take Two was more focused on service intervention rather than direct work with the child, such as a request to work with the carers in their understanding of the child’s situation.

This chapter also places emphasis on the work Take Two undertakes in partnership with other services, such as Child Protection, placement services, family services, mental health, sexual assault and other therapeutic services, Aboriginal services, drug and alcohol services and adult-focused services such as adult mental health and adult drug and alcohol services. This chapter illustrates the significant and multiple needs of this population, but also the importance of a coordinated and committed system. Take Two’s role in providing consultation to Child Protection and other services has substantially grown from the first to the second year and emphasises the growing place that Take Two is assuming within the broader service system.

The chapter commences with an analysis of referrers’ desired outcomes for Take Two’s involvement and then actual interventions with the child, family, carers and service system are described and analysed.

5.2 Desired outcomes of Take Two involvement according to referrers

Referrers list the desired outcomes for intervention in the Take Two Referral Guide. This document is completed for all referrals, except Secure Welfare referrals. The desired outcomes were coded by the research team according to the Take Two outcomes framework as described in Chapter 2 and are presented in Table 20 on the next page.

For the period 2004 and 2005, 309 of the 388 regional and Aboriginal team referrals (80%) specified desired outcomes for Take Two involvement. The missing data is due to not having received Referral Guides from the referrer or this question not being answered within the Referral Guide. There was an average of 3.6 outcomes per referral. The majority of desired outcomes (53%) related to the child wellbeing domain, followed by family and community support (21%), stability, security and connectedness (17%) and child safety (6%).

Within the child wellbeing domain the most common referrer’s desired outcome was ‘enhanced emotional, behavioural, social and/or physical wellbeing’, listed for 77 percent of the clients. The most common desired outcomes within the family and community domain was ‘strengthening parents’, other family and/or carers’ capacity to meet the child’s emotional and other needs’, listed for 55 percent of referrals.

The most common desired outcomes according to the referrers, within the stability, security and connectedness domain was ‘contributing to appropriate, stable and secure placements for the child’, listed for 31 percent of children. For the child safety domain, the most common desired outcome was ‘reduction of harm due to child’s behaviours’, listed for 12 percent of the children.

5.3 Interventions with children, families, carers and the broader system

5.3.1 Background

The nature and focus of therapeutic intervention is influenced by a number of factors such as:

- age and developmental stage of the child;
- the child’s lifetime of individual and collective experiences of trauma, deprivation and disrupted relationships;
- the child’s family and placement relationships - past, present and hoped for future;
• the child’s cultural background and identity;
• the current availability of a nurturing and consistent adult to participate in the therapeutic process either with the child or separately;
• the child’s access to meaningful and positive relationships outside the family or placement context, such as school and community;
• the presentation of the child in terms of developmental, emotional and behavioural difficulties that need to be addressed;
• the expectations, understanding and commitment by the broader system; and
• assessment regarding what is most likely to be effective in terms of engaging the child’s participation in the process and leading to beneficial outcomes.

The length of time available for a Take Two intervention is also a factor. For example, when it is known that Child Protection is going to close the case this indicates that Take Two has limited time, as it can only be involved for up to three months post Child Protection closure. The child’s previous experience of therapeutic interventions and other services is also a useful indicator of what approaches may be more or less beneficial.

The three core elements to the Take Two Practice Framework regarding intervention planning are firstly, the child’s trauma experience and presentation; secondly, their access to nurturing and consistent parents/carers; and thirdly, their developmental level. For example, if a child does not yet have a caring, stable placement, then certain therapeutic approaches are contra-indicated as they would either be unlikely to succeed or could place the child in further emotional turmoil. The child’s family and placement context are critical factors in determining the therapeutic approach and timing as most therapeutic approaches with children assume that they have access to a nurturing, consistent adult figure/s in their lives upon whom they can rely whilst they explore their thoughts and feelings about their experiences. A therapeutic relationship, no matter how intensive, is not a substitute for a nurturing parent or carer. To ask a child to trust a therapist in one, two or even three sessions a week, when life has shown them that adults can be abusive, rejecting or benign but distant, is not a reasonable expectation. Therefore for these children the centre of intervention is to show them that there are some adults who can be trusted to care for them, who will not reject or blame them.

Table 20
Desired Outcomes at Time of Referral to Take Two according to Referrer for Regional and Aboriginal Teams’ Clients in 2004 and 2005

<table>
<thead>
<tr>
<th>Domain (N = 309)</th>
<th>Desired outcomes</th>
<th>N of responses</th>
<th>% of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child Safety</strong></td>
<td>Reduction of harm due to child’s behaviour</td>
<td>36</td>
<td>11.7</td>
</tr>
<tr>
<td>5.5%</td>
<td>Promotion of child’s safety</td>
<td>21</td>
<td>6.8</td>
</tr>
<tr>
<td></td>
<td>Other child safety goals</td>
<td>2</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Child Wellbeing</strong></td>
<td>Recovering from trauma</td>
<td>125</td>
<td>40.5</td>
</tr>
<tr>
<td>52.8%</td>
<td>Reduction of behavioural and/or emotional symptoms</td>
<td>168</td>
<td>54.4</td>
</tr>
<tr>
<td></td>
<td>Improved cognitive and/or language development</td>
<td>9</td>
<td>2.9</td>
</tr>
<tr>
<td></td>
<td>Improved school attendance and/or performance</td>
<td>26</td>
<td>8.4</td>
</tr>
<tr>
<td></td>
<td>Enhanced emotional, behavioural, social and/or physical wellbeing</td>
<td>238</td>
<td>77.0</td>
</tr>
<tr>
<td></td>
<td>Other child wellbeing goals</td>
<td>40</td>
<td>12.9</td>
</tr>
<tr>
<td><strong>Stability/ security/ connectedness</strong></td>
<td>Strengthening attachments and/or forming quality relationships</td>
<td>50</td>
<td>16.2</td>
</tr>
<tr>
<td>16.9%</td>
<td>Strengthening child’s identity, sense of belonging and/or connectedness</td>
<td>33</td>
<td>10.7</td>
</tr>
<tr>
<td></td>
<td>Contributing to appropriate, stable and secure placement for child</td>
<td>95</td>
<td>30.7</td>
</tr>
<tr>
<td></td>
<td>Other stability/security/connectedness</td>
<td>7</td>
<td>2.3</td>
</tr>
<tr>
<td><strong>Family and community</strong></td>
<td>Strengthening quantity and/or quality of informal and/or formal social networks</td>
<td>49</td>
<td>15.9</td>
</tr>
<tr>
<td>20.7%</td>
<td>Strengthening parents’, other family and/or carer’s capacity to meet child’s emotional and other needs</td>
<td>170</td>
<td>55.0</td>
</tr>
<tr>
<td></td>
<td>Other family and community</td>
<td>14</td>
<td>4.5</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>Other desired outcomes</td>
<td>28</td>
<td>9.1</td>
</tr>
<tr>
<td>4.1%</td>
<td><strong>Total</strong></td>
<td>1111</td>
<td></td>
</tr>
</tbody>
</table>

| Missing data | 79 cases |

situations and to provide a calming, soothing and predictable setting for the child. A similar approach may also occur with the school. At the same time, Take Two may work with the child on his or her behaviour and communication patterns, to support increased control over responses to particular situations. This sometimes occurs through cognitive behavioural approaches, play therapy or more indirect methods, such as building a non-intrusive relationship to form a bridge that enables the child to develop other such relationships. The child is not expected to discuss the traumatic experiences until there is an adult in his or her life who is able to be trusted.

In situations where the child has a stable and committed home life or placement, but is showing emotional and behavioural symptoms reflecting the experience of trauma, a direct approach on helping the child to explore and understand the experience is more likely. In these situations work may also occur with the parents, carers and/or school to help them understand the child’s experience so that they can actively listen to the child and respond accordingly.

For younger children such as infants and toddlers (as well as for many older children), the work is dyadic with the child and their parent or carer and/or with the parent/carer on their own. This type of therapeutic intervention enables the child to directly experience the parent or carer as consistent and nurturing. This often involves helping the adults understand their own responses. This type of work aims to help the parents/carers understand how the child needs them regardless of how much the child may be trying to show them that he or she does not need anyone (Dozier, Stovall, Albus, & Bates, 2001). This is referred to as child-focused parent or child-focused carer work and is distinct from interventions with the parents or carers about their own histories of trauma.

5.3.2 Overview of Take Two clinicians’ client activity in 2004 and 2005

Data from Take Two clinicians’ client activity records in 2004 and 2005 enabled analysis of the types and location of services provided by Take Two. This included client activity and related travel time for clinicians, Senior Clinicians’ and Area Managers. As shown in Table 21 the largest component of clinical staff’s time (30%) was spent directly intervening with the children, their families and/or carers. This is in addition to assessment which involved another 18 percent of clinicians’ time. Just over a fifth (22%) of their time was spent on system intervention and networking. As illustrated in the previous chapter, many children are in uncertain, unstable or unsafe situations and work with the system can be essential to support stability and safety prioritised to or in conjunction with individual therapy. Work with the system often follows assessment of the children in their context and then undertaking interventions with the system to change and/or strengthen their environment and relationships.

Near a fifth (19%) of clinicians’ time was spent on receiving or providing supervision and case discussions within team meetings. Both the supervisee and supervisor record these hours, so one hour of supervision would be counted as two hours. Take Two has built in supervision as an integral component of the Practice Framework and program design. Due to the complexity of the client group and the resultant nature of the work required, there is emphasis on collective knowledge rather than individual expertise. As such, supervision includes taking a team approach to understanding the child and system and identifying and implementing appropriate interventions. It can also involve debriefing and support to avoid vicarious trauma, which is a major risk in intensive work.

<table>
<thead>
<tr>
<th>Type of service</th>
<th>% of time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct interventions with child, family and/or carer</td>
<td>30.1</td>
</tr>
<tr>
<td>Interventions with system and networking</td>
<td>21.6</td>
</tr>
<tr>
<td>Supervision/Team discussion</td>
<td>19.0</td>
</tr>
<tr>
<td>Assessments</td>
<td>17.5</td>
</tr>
<tr>
<td>Other</td>
<td>9.2</td>
</tr>
<tr>
<td>Receiving referrals</td>
<td>2.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Note: ‘Other’ includes reviewing files, court activity and follow-up after closure.

Table 22 on the next page provides a more detailed breakdown of direct service provision including travel. The intervention accounting for the largest percentage of time was with children on their own, which was 38 percent of clinical staff’s time. A further seven percent of time was spent providing intervention to the child in conjunction with others, such as parents, family, carers, siblings, school and peers. This did not include the time spent focused on assessment. An example of the distinction between assessment and specialist assessment is when Take Two conducts a cognitive assessment in addition to the standard assessment. How direct intervention is classified compared to systems intervention is exemplified by work with schools. When the work involves the child and teacher it is listed as ‘intervention-child/school’. When the work is only with the teacher, it is described as ‘interventions with the system’ such as that reported on in Table 21. In relation to group work, an approach was piloted within Secure Welfare which registered as 0.1 percent when analysed across the time spent in direct service throughout the state.
The activity with the highest proportion of travel was direct interventions with the child, family or carers. Rural teams (49%) spent more time by EFT in travel than metropolitan teams (38%). The teams which recorded the most client-related travel by EFT were Hume (13%), Loddon-Mallee (12%), Eastern (12%), Southern (10%), Aboriginal (10%) and

Table 22
Type of Direct Service Provided for Take Two Regional and Aboriginal Teams’ Clients in 2004 and 2005

<table>
<thead>
<tr>
<th>Type of service</th>
<th>% of time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment - Child</td>
<td>9.8</td>
</tr>
<tr>
<td>Specialist assessment - Child</td>
<td>2.0</td>
</tr>
<tr>
<td>Assessment - Parent</td>
<td>5.9</td>
</tr>
<tr>
<td>Assessment - Family</td>
<td>3.1</td>
</tr>
<tr>
<td>Assessment - Child’s placement</td>
<td>2.9</td>
</tr>
<tr>
<td>Assessment - Child’s school</td>
<td>1.7</td>
</tr>
<tr>
<td>Assessment - Child’s other contexts</td>
<td>1.1</td>
</tr>
<tr>
<td>Intervention - Child</td>
<td>37.7</td>
</tr>
<tr>
<td>Intervention - Parent</td>
<td>8.0</td>
</tr>
<tr>
<td>Intervention - Child/Parent</td>
<td>3.1</td>
</tr>
<tr>
<td>Intervention - Family</td>
<td>2.5</td>
</tr>
<tr>
<td>Intervention - Child/Carer</td>
<td>2.3</td>
</tr>
<tr>
<td>Intervention - Carer(s)</td>
<td>6.3</td>
</tr>
<tr>
<td>Intervention - Child/Siblings</td>
<td>0.6</td>
</tr>
<tr>
<td>Intervention - Child/School</td>
<td>1.0</td>
</tr>
<tr>
<td>Intervention - Child/Social network</td>
<td>0.3</td>
</tr>
<tr>
<td>Intervention - Group</td>
<td>0.1</td>
</tr>
<tr>
<td>Primary consultation</td>
<td>0.2</td>
</tr>
<tr>
<td>Follow-up after closure</td>
<td>1.2</td>
</tr>
<tr>
<td>Information/communication with child/family</td>
<td>4.5</td>
</tr>
<tr>
<td>Case conference involving family</td>
<td>6.0</td>
</tr>
<tr>
<td><strong>Total of direct interventions</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Service provision took place in a variety of settings. The exception was Secure Welfare where nearly two thirds (64%) of the Senior Clinician’s time was spent in the Secure Welfare Service setting. However, as shown in Table 23, half the staff’s time in direct service took place at Take Two office locations (51%), with 22 percent of time spent at other office locations. Fourteen percent of service provision took place at either the child’s home or placement. A larger percentage of travel time was spent getting to and from the child’s home or placement (27% of travel time) compared to other locations. Even seeing the child in an office sometimes involved travel time, such as when the Take Two clinician transported the child to and from therapy or had to travel to a different Take Two office.

Table 23
Location of Service Provision for Take Two Regional and Aboriginal Teams’ Clients in 2004 and 2005

<table>
<thead>
<tr>
<th>Location of service</th>
<th>% of time in service</th>
<th>% of time in travel</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s family home</td>
<td>5.7</td>
<td>14.5</td>
<td>7.8</td>
</tr>
<tr>
<td>Child’s placement</td>
<td>4.4</td>
<td>12.3</td>
<td>6.3</td>
</tr>
<tr>
<td>Take Two office</td>
<td>61.6</td>
<td>15.0</td>
<td>50.5</td>
</tr>
<tr>
<td>Other offices</td>
<td>17.2</td>
<td>35.7</td>
<td>21.6</td>
</tr>
<tr>
<td>Secure Welfare</td>
<td>1.4</td>
<td>2.6</td>
<td>1.7</td>
</tr>
<tr>
<td>School/Preschool</td>
<td>3.4</td>
<td>9.5</td>
<td>4.9</td>
</tr>
<tr>
<td>Public area</td>
<td>2.2</td>
<td>4.3</td>
<td>2.7</td>
</tr>
<tr>
<td>Car</td>
<td>2.6</td>
<td>3.1</td>
<td>2.7</td>
</tr>
<tr>
<td>Other</td>
<td>1.5</td>
<td>3.1</td>
<td>1.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Barwon South West (10%). Consistent with the location of service, the team with the least travel was Secure Welfare (3%). The next team with the least amount of travel was the Gippsland team (7%). This shows that although overall rural teams spent more time in travel than metropolitan teams, this was influenced by local factors. For example, in the Hume region, the Take Two team is split over two areas (Seymour and Wangaratta), yet a reasonable proportion of their clients live in a third area (Shepparton). In contrast, much of the work undertaken by the Gippsland team was located around the regional centre of Morwell where Take Two has its office.

5.3.3 Overview of interventions in 2005

The Take Two clinician survey, completed for every open case in 2005, not including Secure Welfare (N = 352), included a question regarding interventions. Staff journals supplemented the analysis by providing descriptions of interventions. Case studies in Chapter 6 provide exemplars.

Table 24 provides a summary of the types of Take Two interventions according to the clinician surveys. Multiple types of interventions were used for the majority of cases. A number of clinicians listed different examples under each of the types of interventions. For example, some clinicians described both the use of cognitive behavioural therapy and play therapy with the same child. These are both categorised as ‘individual therapy with child’. The table shows both the total number of times any of these interventions were listed and how many cases had at least one of these types of interventions.

<table>
<thead>
<tr>
<th>Types of interventions</th>
<th>N of times listed in survey (N = 326)</th>
<th>N of times listed at least once per case (N = 326)</th>
<th>% of cases that proceeded &amp; assessment complete (n = 343)</th>
<th>% of cases that proceeded &amp; assessment complete (n = 313)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual therapy with child</td>
<td>320</td>
<td>225</td>
<td>65.6</td>
<td>71.9</td>
</tr>
<tr>
<td>Child-focused parent work</td>
<td>98</td>
<td>90</td>
<td>26.2</td>
<td>28.8</td>
</tr>
<tr>
<td>Child-focused carer work</td>
<td>94</td>
<td>87</td>
<td>25.4</td>
<td>27.8</td>
</tr>
<tr>
<td>Family sessions</td>
<td>54</td>
<td>54</td>
<td>15.7</td>
<td>17.3</td>
</tr>
<tr>
<td>Parent-child work</td>
<td>32</td>
<td>31</td>
<td>9</td>
<td>9.9</td>
</tr>
<tr>
<td>Carer-child work</td>
<td>20</td>
<td>19</td>
<td>5.5</td>
<td>6.1</td>
</tr>
<tr>
<td>Work with siblings</td>
<td>18</td>
<td>17</td>
<td>5</td>
<td>5.4</td>
</tr>
<tr>
<td>Systems work</td>
<td>320</td>
<td>217</td>
<td>63.3</td>
<td>69.3</td>
</tr>
<tr>
<td>Systems work with school</td>
<td>78</td>
<td>77</td>
<td>22.5</td>
<td>24.6</td>
</tr>
<tr>
<td>Assessment focus</td>
<td>67</td>
<td>65</td>
<td>19</td>
<td>20.8</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>12</td>
<td>3.5</td>
<td>3.8</td>
</tr>
<tr>
<td>Assessment in progress</td>
<td>14</td>
<td>12</td>
<td>3.5</td>
<td></td>
</tr>
<tr>
<td>Case did not proceed</td>
<td>21</td>
<td>21</td>
<td>6.1</td>
<td></td>
</tr>
</tbody>
</table>

Note. Final column includes three cases where assessment was still in progress, but individual work had begun.
5.3.4 Cases that did not proceed past preliminary involvement

Almost all of the cases open in 2005 proceeded past preliminary involvement. In relation to the 343 cases open in 2005 where data were available, 21 cases (6%) did not proceed and so no interventions were recorded. Of the small percentage that did not proceed, less than two percent were due to the child (n = 3) or family (n = 2) refusing to participate.

Other reasons for not proceeding were due to changes in Child Protection decisions such as referral to an alternate service or the child leaving the state. Eight of these 21 children were in the one sibling group.

There were no significant differences regarding whether these 21 cases were from rural or metropolitan areas, gender or whether the child was Aboriginal. In terms of whether there were differences associated with the child's age and the case not proceeding, significantly more were adolescents ($\chi^2(2) = 7.7, p < .05$).

5.3.5 Clients or families refusing involvement

There was a total of 15 cases (4%) open in 2005 that were closed either in the preliminary stages or at a later point due to the child or family refusing ongoing Take Two involvement. As stated in Chapter 4, all of the cases closed in 2005 due to the child or family refusing involvement were referred in 2004.

This result of 96 percent participation rate would be extremely positive for most populations, but is extraordinary for children and families where abuse and trauma have occurred, as they have been noted in other studies to have a low service participation rate (e.g., McKay, Lynn, & Bannon, 2005). This endorses the emphasis Take Two places on taking responsibility for engaging the child and their family and carers.

For the cases where the children refused, age was the only significant difference, as these were more likely to be adolescents than younger children ($\chi^2(2) = 9.8, p < .01$). In terms of family refusing the service, the only significant difference found was that none of these families were from rural areas ($\chi^2(1) = 5.98, p < .05$).

5.3.6 Individual interventions with children

As summarised earlier, direct therapeutic intervention with children was undertaken for the majority of cases (72%), though usually in conjunction with other interventions, such as parent or carer work and system intervention.

An example of individual intervention with children is play therapy where the child is provided a safe place to explore their feelings and experiences through use of dolls, drawings, puppets, board or card games, toys and other games. This is a well-established and age appropriate means to help children express how they experience their development stage not being appropriate for most individual work ($\chi^2(2) = 23.23, p < .001$). The most frequent age group for this type of intervention was that between the ages of 9 and 12 years. Although the majority of children living with one or both parents at the time of referral received individual therapy, this was a smaller group compared to children living in varied out-of-home care settings ($\chi^2(4) = 10.11, p < .05$). Aboriginal children were significantly less likely to receive individual therapy than non-Aboriginal children ($\chi^2(1) = 3.96, p < .05$). There were no significant differences with undertaking individual therapy approach both verbal and non-verbal techniques are used to enable children to have a sense of personal safety within the therapeutic relationship so that they can explore issues that may make them afraid or ashamed to say out loud. The clinician may interpret what they are seeing and hearing for the child, so that they become a mirror that enables the child to consider if this interpretation of his or her experience is accurate and what other meanings it may have. A narrative approach places emphasis on the child developing a meaningful story of the experiences and may involve use of metaphors and other symbolic work to help the child directly and indirectly explore these issues.

Other direct interventions with children, when considered appropriate, included behaviour management and cognitive behavioural approaches. Children were provided information about what their behaviours may be about and what factors may positively or negatively reinforce these behaviours. Psycho-education about the abuse or neglect experience and about their own behaviours and emotional responses is a core component of these approaches. The children are shown strategies to assist in challenging unhelpful thoughts and to modulate their moods and behaviours. As one clinician wrote:

*I feel that my understanding of trauma theory is becoming more consolidated and therefore more readily able to be utilised in my work. For example, I was recently able to explain some aspects of the theory to a 16 year old client for whom the information was meaningful and liberating.*

(Staff journal)

Take Two clinicians wrote of various strategies they used to facilitate individual therapy, such as pro-active use of outreach, driving with the child in a car so that the focus was not on eye-contact, patience and timing. The use of games was useful as both an engagement strategy and for direct therapy.

The staff journals reflected interventions used by clinicians and the value of providing intensive therapeutic intervention. For example, a clinician wrote about the value of being able to be a constant in these children's ever-changing worlds:

*When I got to school my client saw me and came running across the playground. He then remained by my side for a further 40 minutes, venturing forth periodically to do tricks on the bars etc. It was a moment when I realised how therapeutic being able to follow these [children] has been, I have been everywhere, in the cubby, at mums, at dads, at school, with whatever carer they are with at the present moment.*

(Staff journal)

Some significant differences were found for individual therapeutic interventions with children. The lowest proportion of individual therapy was with infants due to their developmental stage not being appropriate for most individual work ($\chi^2(2) = 23.23, p < .001$). The most frequent age group for this type of intervention was that between the ages of 9 and 12 years. Although the majority of children living with one or both parents at the time of referral received individual therapy, this was a smaller group compared to children living in varied out-of-home care settings ($\chi^2(4) = 10.11, p < .05$). Aboriginal children were significantly less likely to receive individual therapy than non-Aboriginal children ($\chi^2(1) = 3.96, p < .05$). There were no significant differences with undertaking individual therapy...
with children and whether the child lived in metropolitan or rural areas or their gender.

5.3.7 Interventions with children and their families and carers

Take Two undertook family-based interventions with 104 children which included family therapy, parent-child dyadic work, carer-child dyadic work and sibling therapy. Family therapy sessions involve all or some of the immediate family members and sometimes extended family and community members. Some sessions were with the child and the carer’s family, but the majority involved the child’s biological family. As shown in Table 24, family therapy sessions occurred for 54 (17%) cases. The focus of family therapy is usually on relationships, communication patterns, boundaries and developing a shared understanding of each other’s experiences and emotional responses. For example, the therapist may enlist the child’s carer or family member/s to bear witness for the child about their traumatic experiences and their process of recovery (White, 2006).

Family therapy sessions can be very dynamic and at times chaotic and so may sometimes benefit from more than one clinician. This could be a factor in why the only significant difference found regarding family therapy sessions is that it was more likely to occur in metropolitan than rural areas, which have larger teams ($X^2(1) = 12.1, p < .01$). This contrast between metropolitan and rural areas continued when all the different types of family interventions were combined ($X^2(1) = 11.98, p < .01$). There were no significant differences between use of family therapy and the child’s age, gender or Aboriginal identity.

Parent-child or carer-child dyadic work is where the therapeutic focus is on the relationship between the parents or carers and the children. An example of this approach is Lieberman and Van Horn’s (2004) work with young children and their mothers who have experienced family violence. Another example is Trauma-Focused-Cognitive Behavioural Therapy (Deblinger & Hefflin, 1996) which includes a combination of individual child work, individual parent work and dyadic parent-child work. Both of these approaches are trauma-informed, with Lieberman and Van Horn’s approach placing greater emphasis on attachment. Both examples include psycho-education and practising of newly acquired skills. With younger children, the emphasis is more on helping the parent or carer to take the initiative in the relationship with the child. For older children and adolescents this can vary. Dyadic work is predicated on the availability of a parent or carer who is willing to participate in these and related approaches.

With each example of family intervention there was no significant difference in relation to Aboriginal identity; however, when all types of family interventions were combined, Aboriginal children were significantly less likely to be involved in family therapy than non-Aboriginal children ($X^2(1) = 6.07, p < .05$).

Parent-child intervention was significantly more likely to occur when the child was living with one or both parents at the time of referral ($X^2(4) = 11.85, p < .05$). When all family work was combined a similar significant difference was found, in that it was more likely when the child lived with his or her family ($X^2(4) = 10.19, p < .05$).

In terms of carer-child interventions there were no significant differences associated with age, gender, Aboriginal identity, rural or metropolitan location or type of placement. Even children who were initially placed with their family had a similar proportion of carer-child therapy, indicating that they probably went into out-of-home care during Take Two involvement. In contrast, although most children were placed in some form of out-of-home care at time of referral to Take Two, more children were involved with parent-child therapy (10%) than carer-child therapy (6%).

Only a small percentage of cases (5%) involved therapeutic work with two or more siblings as a group. This approach may occur when there is an opportunity for the siblings to support each other to explore their experiences and reactions or when there is a concern regarding their interaction. No sibling interventions were undertaken with adolescents and it was more likely with children aged between 6 and 12 years ($X^2(2) = 11.93, p < .01$).

Age was not a significant variable in terms of which cases involved family interventions other than work with siblings. However, when looking at the combinations of family-based interventions, younger children were significantly more likely to be involved than older children ($X^2(2) = 12.0, p < .01$).

Strategies mentioned in staff journals about working with families included empowering families; helping parents to reflect on their own contribution to the difficulties; and playing down the clinician’s knowledge with families, so that they could discover the child together, ‘to watch and wonder - so as not to appear expert.’ This follows a particular therapeutic approach known as ‘Watch, Wait and Wonder’ (Cohen, et al., 1999).

5.3.8 Child-focused interventions with parents and carers

As stated earlier, 29 percent of the interventions were child-focused parent work and 28 percent were child-focused carer work. This is interesting given the substantially larger proportion of children living in out-of-home care. It may reflect that the case plan for many of these children is reunification. In 20 cases, where the children moved from living with parents to a placement or vice versa, both child-focused parent and child-focused carer interventions were implemented. In a couple of situations this occurred prior to the reunification or placement change which supported the parents or carers to emotionally prepare the child to live with or separate from them.

Cognitive behavioural therapy is an example, as already mentioned, of an intervention where work with the parents or carers is focused on helping them to understand and respond effectively to the child. This and other approaches help the parent or carer to consider what the child has experienced and the implications of this for the child’s wellbeing, behavioural responses, learning and developmental needs and in particular what they need from the parent or carer. As with dyadic work, child-focused parent or carer interventions require that there is a consistent and available parent figure or caregiver available to participate in therapy.

In 2005, according to the Take Two clinician surveys, significantly more child-focused parent work occurred in metropolitan areas than rural ($X^2(1) = 18.6, p < .001$).
were no other significant differences found with this type of intervention in terms of age, gender, Aboriginal identity or placement at time of referral. The latter reinforces the likelihood that such approaches were utilised with children in the process of reuniting or attempting to reunite with their families, as well as children already living at home.

Although child-focused carer work occurred for more infants than other age groups, this was not significant. The only significant difference found with child-focused carer work was that the children were more likely to be in home-based care, such as foster care, and less likely to be with one or both parents at time of referral ($X^2 (4) = 14.97, p < .01$).

A theme of working with families and carers was highlighted in the staff journals. For example, one clinician wrote of the impact of the complex lives of these children on carers.

*I've been reminded of how undervalued people who directly care for children really are. It doesn't seem to matter if they are teachers, child care workers, 'good enough parents', foster carers or paid residential staff; the complexity and potency of their work is either not understood or not valued. It's as if, as a society, we really cannot tolerate thinking about how important the well being of children really is.* (Staff journal)

### 5.3.9 Interventions with the system

Take Two staff journals portrayed the clinicians' awareness of Take Two as part of the service system and the importance of working within this system. Take Two intervened at the service system level for 71 percent of clients, as stated earlier. There were no significant differences regarding the use of systems intervention and clients, as stated earlier. There were no significant differences found with this type of consultation was usually in addition to individual consultations regarding cases to workers and carers. This type of consultation was usually in addition to individual and family work.

The staff journals often expressed a level of frustration with system intervention whilst acknowledging it was a critical component to the work of Take Two. At times work with the system was experienced as confronting and highlights the importance of gaining knowledge of the complex service system and 'developing an understanding of how decisions get made and how that impacts on us' (Staff journal). The most frequent frustration related to case management, such as when the case was unallocated; a change in case managers; an implied expectation of Take Two undertaking a case management role; or when there was disagreement regarding the case management/case planning direction.

Examples of system interventions that emerged from the journals included the importance of facilitating a team approach, regular contact with key workers, providing information to the system about the child, focusing on developing relationships and ensuring open communication. There was mention of the role of Take Two in assisting the service system with the high level of anxiety sometimes generated around particular cases and facilitating change of attitudes and beliefs about the child.

### Working with Child Protection:

The ongoing process of an effective working relationship with Child Protection was addressed in the staff journals. Structural and programmatic developments were acknowledged as assisting in the broader relationships within the child protection system, such as the Regional Advisory Groups, regular meetings with regional Unit Managers, and providing Help Desk consultancy functions.

Staff journals reflected understanding of the difficult role of Child Protection and the perception by some that Child Protection workers are not always afforded sufficient reflective space. Challenges included working collaboratively with Child Protection and at the same time advocating for changes in the system.

System interventions with Child Protection, in addition to the care team function, include psycho-education about the impact on the children of their past and current experiences; advocacy; providing evidence in court; attending case conferences and case planning forums; and making recommendations regarding future intervention and planning. In some situations Take Two has undertaken a detailed file review and provided feedback to Child Protection and other services regarding the findings from these reviews. These provide an opportunity to reflect on the learnings embodied within a case file separate to having a major critical incident or adverse event.

### Working with the child's placement:

The importance of carers having knowledge and understanding of trauma was mentioned in some Take Two staff journals. One clinician in her journal wrote of the highlight for the month when visiting a foster home with a number of children.

*The home was a excellent example of how routine, structure, boundaries and a great deal of warmth allows our kids to blossom.* (Staff journal)

Interventions with carers, such as child-focused carer work, can also be understood as systems work, although it has not been included in these figures for the sake of clarity. Other systems work undertaken with the child’s placement has focused at the case manager and organisational level, such as providing psycho-education and consultation to a residential team and management. It can involve work with the carer and foster care worker on behavioural approaches predictable on understanding the child’s experience of trauma and disrupted attachment within a culture of care and emotional containment for the child.

### Working with the school:

For 77 children (25%), Take Two undertook an active role with the child’s school or preschool. This work often entailed psycho-education, advocacy and shared problem-solving. There were significant differences associated with system intervention with schools. For example, work with schools
was significantly more likely to occur for children living in the metropolitan areas ($\chi^2(1) = 8.7, p < .01$) and for children of primary school-age compared to children under the age of six and adolescents ($\chi^2(2) = 8.34, p < .05$). Interventions with schools were significantly more likely for male children ($\chi^2(2) = 8.75, p < .01$).

The importance of the school in the lives of children is illustrated in Chapter 7 on social networks. It is also emphasised in State Government policy such as through the DHS-Department of Education partnering agreement and in the Looking After Children initiative. The following three quotes from staff journals illustrate the importance that Take Two clinicians placed on working with schools.

**In working with schools ... I have found it most beneficial to attend on their home ground. Not only is it easier for them (and you recognise this) but it affords the opportunity to assess the school environment on a more informal basis.** (Staff journal)

**Very important to go out to schools and maintain contact with school staff as they are often the most structured and reliable environments for particular children. Also get a broader picture of the child’s world and how they interact.** (Staff journal)

**I have had a client move from one town to another. The challenge has been to re-engage with her after the move ... so far unsuccessful. The challenges lay around engaging with a new school system - the previous one was extremely supportive, the new one I haven’t worked with before and does not know the program.** (Staff journal)

5.3.10 Interventions by Take Two within the Secure Welfare Service

In 2004 and 2005, most of the interventions by Take Two within the Secure Welfare Service were conducted by the Take Two Secure Welfare Senior Clinician. However, members from the Aboriginal team are often requested by the Secure Welfare Senior Clinician to respond with Aboriginal children. Regional clinicians undertake the majority of assessment and interventions within the Secure Welfare Service of children who are already clients of the regional Take Two service.

According to the client activity records completed by the Take Two Senior Clinician nearly two thirds of that role took place at either the Young Men’s or Young Women’s Secure Welfare units. This is consistent with the closed setting of the Secure Welfare service. Another 25 percent of the Senior Clinician’s time was at the Take Two office.

In terms of type of service provided by the Take Two role in the Secure Welfare Service, the largest percentage of direct service time (44%) is assessment of the young person. An additional five percent of the direct service time is in assessment of the young person’s family or broader context. Eleven percent of time was in meetings with the young person’s family. Eight percent of direct service time was in following-up the young person or their family after he or she was discharged from the Secure Welfare Service.

5.4 Other service systems involved

According to the Take Two clinician surveys and the Child Protection records, a large number and variety of services were involved with these children before and during Take Two’s involvement. All the children were involved with Child Protection as this is a criterion for referral. A number of different organisations within the same classification of service were listed for many children and so Table 25 shows both the overall number of services listed and then the number and percentage per client.

<table>
<thead>
<tr>
<th>Types of services</th>
<th>N</th>
<th>N per case</th>
<th>% of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placement agency (CSO)</td>
<td>274</td>
<td>217</td>
<td>65.8</td>
</tr>
<tr>
<td>CAMHS</td>
<td>47</td>
<td>45</td>
<td>13.6</td>
</tr>
<tr>
<td>Other mental health service - child</td>
<td>25</td>
<td>24</td>
<td>7.3</td>
</tr>
<tr>
<td>Adult mental health service</td>
<td>33</td>
<td>26</td>
<td>7.9</td>
</tr>
<tr>
<td>Sexual assault service</td>
<td>20</td>
<td>16</td>
<td>4.8</td>
</tr>
<tr>
<td>Other counselling service (e.g. private)</td>
<td>58</td>
<td>48</td>
<td>14.5</td>
</tr>
<tr>
<td>Secure Welfare</td>
<td>32</td>
<td>32</td>
<td>9.7</td>
</tr>
<tr>
<td>Disability Services</td>
<td>14</td>
<td>13</td>
<td>3.9</td>
</tr>
<tr>
<td>Youth Justice</td>
<td>30</td>
<td>28</td>
<td>8.5</td>
</tr>
<tr>
<td>School</td>
<td>267</td>
<td>200</td>
<td>60.6</td>
</tr>
<tr>
<td>Department of Education</td>
<td>50</td>
<td>43</td>
<td>13</td>
</tr>
<tr>
<td>Family Service</td>
<td>92</td>
<td>74</td>
<td>22.4</td>
</tr>
<tr>
<td>Aboriginal organisation</td>
<td>47</td>
<td>30</td>
<td>9.1</td>
</tr>
<tr>
<td>Medical service</td>
<td>59</td>
<td>52</td>
<td>15.8</td>
</tr>
<tr>
<td>Drug and alcohol service - child</td>
<td>20</td>
<td>18</td>
<td>5.5</td>
</tr>
<tr>
<td>Drug and alcohol service - adult</td>
<td>9</td>
<td>9</td>
<td>2.7</td>
</tr>
<tr>
<td>Other</td>
<td>201</td>
<td>108</td>
<td>32.7</td>
</tr>
</tbody>
</table>

**Total** | **1592** |

**Table 25**

*Type of Services Working with Children during Take Two Involvement for Regional and Aboriginal Teams’ Open Cases in 2004 and 2005 (N = 330)*

**Note.** There were missing data regarding the type of services involved in 22 cases.
The range of services per child was 1 to 16, with a mean of 4.9 services (SD = 3.0). Following is an analysis comparing demographics of the Take Two client group and their use of other services. A caution is that no conclusions can be drawn from this regarding the usual client groups of these services, but only those they share with Take Two.

5.4.1 Department of Human Services
As 100 percent of the Take Two client group is involved with Child Protection, there was no further analysis of the statistical differences between Take Two and that service.

According to the clinician surveys, 32 young people in the regional and Aboriginal teams were involved with the Secure Welfare Service (10%) during Take Two involvement.

This is in addition to those young people involved with the Take Two role located at the Secure Welfare Service. Their age followed the guidelines for Secure Welfare involvement with all of them nine years or older ($X^2(5) = 59.08, p < .001$). Although there were slightly more females than males this was not significant in contrast to the general Secure Welfare Service population and the Take Two Secure Welfare client group. There were more young people likely to have been placed in residential care at the time of referral to Take Two ($X^2(4) = 26.87, p < .001$), although some had been living with their parent/s.

Another DHS service involved with Take Two clients was Youth Justice (8%). Similarly to the Secure Welfare Service, the legislation limits the age groups involved with Youth Justice. As such there were no children under the age of ten and only one child aged 11 years old. This difference was significant ($X^2(5) = 55.53, p < .001$). Fifteen percent of children who were old enough (i.e. 10 years or older) were involved with Youth Justice. The largest number were between the ages of 12 and 14 years, although the greatest proportion per age group were those 15 years and older. Children involved with Youth Justice were more likely to be in residential care at time of referral to Take Two than any other placement, although the second largest placement type was living with one or both parents ($X^2(4) = 45.96, p < .001$). There were no significant differences associated with being a Youth Justice client and the child’s gender or Aboriginal identity.

Disability Services is another DHS service that was involved with a small number (4%) of Take Two clients. There were no children under the age of three involved with Disability Services or Specialist Children’s Services, although this difference was not significant. There were no significant differences with children involved in these services and demographic information, possibly because the numbers were so small.

5.4.2 Out-of-home care services
Two hundred and ten children (63%) were in service-based out-of-home care at the time of referral to Take Two, such as home-based care and residential care. According to the clinician surveys, 217 (66%), children had some involvement with a Community Service Organisation-placement agency during Take Two involvement. As expected, children in home-based care and residential care services were significantly more likely to have a Community Service Organisation-placement service involved compared to those living at home or in kinship care at time of referral ($X^2(4) = 102.28, p < .001$). Nevertheless, there was a reasonable percentage of those living at home or in kinship care (31% and 32% respectively) that had such a service involved. These children may have been placed in out-of-home care some time following the referral to Take Two.

5.4.3 Family services
Community Service Organisations provided family services, such as family support and family preservation services, to 22 percent of children and their families. Children under the age of 3 were significantly more likely to receive a family service than young people 15 years or older ($X^2(5) = 14.22, p < .05$). Girls were significantly more likely to be involved with family services than boys ($X^2(1) = 4.31, p < .05$). Children living with their parent/s at the time of referral to Take Two were significantly more likely to be involved with family services compared to children in out-of-home care, such as home-based care or residential care ($X^2(4) = 24.31, p < .001$).

5.4.4 Preschool and schools
Three fifths (61%) of the clinician surveys listed the children’s involvement with schools, although this is probably an underestimate as not all clinicians recorded universal services such as education and health. Another 13 percent recorded the child receiving services during Take Two involvement from the Department of Education, such as a Guidance Officer. Education services were significantly more likely to occur for Take Two clients who were in residential care and home-based care compared to children in kinship care ($X^2(4) = 15.43, p < .01$).

5.4.5 Medical services
Similarly to the issue of schools, the number of medical services is a likely underestimate due to not all clinicians including universal services in response to this question. However, 16 percent of the children had reportedly some involvement with medical services. No significant differences were noted between the use of medical services and the client demographics.

5.4.6 Mental health and counselling services
Mental health services were involved with a substantial proportion of clients, with 14 percent being clients of CAMHS during Take Two involvement; and a further 7 percent being clients of another child mental health service, such as a private therapist. A further five percent were involved with a sexual assault service. Adult mental health was cited as being involved with eight percent of Take Two cases. Other types of counselling services were involved with another 15 percent of children or their families.

Take Two straddles both the child welfare/child protection system and the mental health system and so often plays a valuable role in terms of their interface. Nevertheless, there is continued confusion regarding the nexus between Take Two and CAMHS. Examples where both Take Two and CAMHS were involved included where the children required in-patient treatment and/or mental health case management, such as in relation to monitoring their medication. Other examples included where CAMHS undertook the individual work and Take Two worked within the family or placement. In these situations the communication and coordination between the two services were essential.
In terms of those children involved in CAMHS and Take Two, there was a significant difference with the child’s age, where CAMHS were not involved with any of the children under the age of three and only two children between the age of three and six years ($X^2(5) = 12.99, p < .05$). CAMHS were more likely to be involved with young people between the ages of 12 and 15 years, followed by those between 9 and 12 years. When Take Two client’s involvement with other counselling services was analysed, the pattern was different with children under the age of three years being significantly more likely to be involved with other counselling services ($X^2(5) = 15.88, p < .01$). However, this classification is difficult to further analyse as it was not possible to determine whether some of these services were adult or child-focused. Although there was no significant difference found between Aboriginal identity of Take Two clients and CAMHS involvement, it was less likely for Aboriginal children to be involved with other counselling services ($X^2(1) = 4.47, p < .05$).

CAMHS were significantly more likely to be involved with boys than girls ($X^2(1) = 4.16, p < .05$). CAMHS services were more likely to be involved with children in residential care compared to those in kinship care ($X^2(4) = 20.22, p < .001$). Other mental health services were also more likely to be involved with children living in residential care ($X^2(4) = 20.57, p < .001$).

Sixteen children involved with Take Two in 2005 were involved in a sexual assault service, the majority of whom (69%) were boys. This was not a statistically significant difference, but given the smaller amount of sexual abuse reported for boys it was unexpected. This is especially as most of these boys were pre-adolescent or adolescent with a mean age of 11.3 years, where the gender difference is usually more pronounced.

Adult mental health services were significantly more likely to be involved with Take Two clients if the child was a girl ($X^2(1) = 5.91, p < .05$). Adult mental health services were also significantly more likely to be involved when the Take Two client was Aboriginal ($X^2(1) = 10.06, p < .01$). Adult mental health services were significantly more likely to be involved when the child was in residential care at the time of referral to Take Two ($X^2(4) = 20.34, p < .001$). This is in contrast to children who were in kinship care, where none of their families were involved with adult mental health services.

### 5.4.7 Aboriginal services

Nine percent of children were involved with an Aboriginal agency. Sixty percent of Aboriginal clients of Take Two were involved with an Aboriginal service. These services included the Aboriginal Child Specialist and Support Service, Aboriginal family services, Aboriginal out-of-home care services, Aboriginal family preservation programs and Aboriginal health services and co-operatives. Only Aboriginal children were involved with Aboriginal services; however, there was concern that for 40 percent of the Aboriginal clients involved with Take Two there was no mention of Aboriginal services. Take Two’s Aboriginal team has been instrumental in assisting in the establishment of relationships between Take Two and Indigenous services.

### 5.4.8 Drug and alcohol services

Other services for Take Two clients included drug and alcohol services, both child (6%) and adult (3%). All the young people involved with drug and alcohol services were 12 years or older. A large proportion of young people involved with drug and alcohol services were in residential care ($X^2(4) = 32.81, p < .001$).

Although the numbers of families reported as being involved with adult drug and alcohol services were small a couple of significant differences were found. These children were more likely to be girls ($X^2(1) = 7.11, p < .05$) and were more likely to be Aboriginal ($X^2(1) = 7.16, p < .05$).

### 5.5 Consultations

The value of Take Two’s role in providing consultation to Child Protection, the Secure Welfare Service and Community Service Organisations was raised in the feedback received by a number of organisations during the first evaluation (Frederico, Jackson, & Black, 2005). Although not required in the original specifications, discussions with DHS both centrally and regionally have confirmed the importance and appreciation of Take Two’s consultation role. There have been a number of avenues by which this role has been provided:

- Take Two’s Help Desk role as described earlier, whereby regular visits by Take Two occur at Child Protection and VACCA offices to proactively encourage consultations and assist with potential referrals.
- Ad hoc requests for consultations on a case by case basis, usually by phone.
- Take Two staff regularly attending meetings regarding specific children or group of children, such as children in a residential unit.
- Specific requests for Take Two to provide in-depth consultation regarding a particular child or system issues impacting on children.

In 2004, the number of consultations provided by Take Two was estimated at 388 for the year. In 2005, this number rose to 1931 (as shown in Table 26). This represents nearly a 400 percent increase. It is not clear if this is due to an increase in consultations or better recording by Take Two. As identifying information is not able to be collated regarding consultations, it is not possible to determine the number of children who were the subject of these consultations. An estimate based on a sample of cases is that each child may be the subject, on average, of two to three consultations. More consultations were recorded by the metropolitan teams although this is influenced by the Northern team’s higher number of consultations compared to other teams.

It is worth noting the disproportionately higher amount of consultations compared to size of teams for the Aboriginal team and the Secure Welfare position.
During 2005, additional demographic information was collected regarding consultations. Although there is considerable missing data, it was considered indicative of the nature of the children for whom consultation was sought. Figure 17 shows the age breakdown for 1590 consultations (82% of the total number of consultations). As seen in this graph, the largest proportion of children who were the subject of consultations was between 12 to 15 years of age. There was a very low proportion of consultations regarding children under the age of three years. In terms of gender, 61 percent of the consultations were regarding male children.

In terms of Aboriginal identity, there are considerable missing data; however, this information was recorded in relation to 1527 (79%) consultations. The Aboriginal team clearly undertook the largest amount in terms of both number and percentage of consultations regarding Aboriginal children. However, they also provided a small amount (4%) of consultations regarding non-Aboriginal clients. The next highest team who provided consultations regarding Aboriginal children was the Southern team with 87 (69%) of their consultations being about Aboriginal children. Fifty percent of the Hume team’s consultations were in relation to Aboriginal children. The Eastern and Western teams have not as yet provided consultations regarding Aboriginal children.

### Table 26
Consultations Provided by Take Two Team in 2005

<table>
<thead>
<tr>
<th>Take Two team</th>
<th>N of consultations</th>
<th>% of consultations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barwon South West</td>
<td>123</td>
<td>6.4</td>
</tr>
<tr>
<td>Gippsland</td>
<td>119</td>
<td>6.2</td>
</tr>
<tr>
<td>Grampians</td>
<td>145</td>
<td>7.5</td>
</tr>
<tr>
<td>Hume</td>
<td>243</td>
<td>12.6</td>
</tr>
<tr>
<td>Loddon-Mallee</td>
<td>135</td>
<td>7.0</td>
</tr>
<tr>
<td><strong>Sub-total rural teams</strong></td>
<td><strong>765</strong></td>
<td><strong>39.6</strong></td>
</tr>
<tr>
<td>Eastern</td>
<td>49</td>
<td>2.5</td>
</tr>
<tr>
<td>Northern</td>
<td>350</td>
<td>18.1</td>
</tr>
<tr>
<td>Western</td>
<td>169</td>
<td>8.8</td>
</tr>
<tr>
<td>Southern</td>
<td>236</td>
<td>12.2</td>
</tr>
<tr>
<td><strong>Sub-total metro teams</strong></td>
<td><strong>804</strong></td>
<td><strong>41.6</strong></td>
</tr>
<tr>
<td>Aboriginal</td>
<td>167</td>
<td>8.6</td>
</tr>
<tr>
<td>Secure Welfare</td>
<td>161</td>
<td>8.3</td>
</tr>
<tr>
<td>Leadership Group</td>
<td>34</td>
<td>1.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1931</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

5.6 Summary

This chapter has highlighted the depth and breadth of the work undertaken by Take Two clinicians. The chapter portrays the innovative work being undertaken by Take Two and the challenge experienced in finding effective interventions with highly traumatised children and families. The role of Take Two in bringing expertise to support and strengthen the service system has been presented. This chapter illustrates the complex world of Take Two clients and the importance of all components of the service system proactively working together in the child’s best interests.
Chapter 6: Children's stories

6.1 Overview
Case studies are a valuable tool to explore and illustrate the complex lives of children who have experienced maltreatment and to describe the assessments, interventions and outcomes associated with Take Two service delivery. This chapter provides analysis of 29 case studies and intersperses this analysis with the presentation of nine of these case studies to illustrate some of the emerging themes from the evaluation of Take Two. These case studies were purposefully selected to present examples of intervention. They are not intended to be representative, but rather illustrative. The case studies demonstrate the developing Take Two Practice Framework and the interventions and outcomes embedded within. The Practice Framework is based upon theory, research and values and in this chapter some of the literature is integrated with the analysis of these children's stories.

6.2 The analysis of case studies
Each of the children's lives as seen in the case studies is complex and unique. The case studies are a rich source of data on the traumatic situations experienced by children and portray Take Two's intervention and observed changes for the children and their situation. As part of the staff journal methodology, clinicians were asked to provide a case study that demonstrated the nature of the client group, the interventions used by Take Two and how these may have led to specific outcomes. Twenty-nine case studies were provided for analysis. Information provided by the Take Two clinicians was cross-referenced with referral documentation and any outcome measures received regarding these children. The names and certain details of the stories have been changed to ensure that they remain non-identifiable, but the essence has remained the same.

Analysis of these stories begins with an outline of the family structure and then a description of the child's presentation at time of referral to Take Two. There is a summary of what is known about the children's experience of trauma and of key relationships. Each case study charts the interventions by Take Two in order to provide greater insight into what actually occurs within therapy. Finally, the analysis explores some of the outcomes relating to the children's relationships with others and their emotional and behavioural strengths and difficulties. Throughout the case presentations, relevant literature is summarised that provides insight into the meaning behind the child's experience and behaviours or the basis for particular interventions. Nine case vignettes are presented to illustrate the themes and lessons learnt in greater depth, three of which are in relation to the one family. They were selected to give an illustration of the different types of situations and approaches undertaken by Take Two. They include cases from rural and metropolitan teams, a client of Secure Welfare Take Two, a client of the Aboriginal team and a case involving three siblings. Diagrammatic presentations of some of the children's history in the protection system are also displayed.

The ages of the children in the 29 case studies range from one to 17 years with a mean age of ten years. From three years and older the range was reasonably evenly spread across the different age groups. The fewer younger children is indicative of the general Take Two client group and was noted in some of these cases as a lost opportunity given the absence of an earlier intervention. This was a similar finding to that of 'When Care is not Enough' (Morton, Clark, & Pead, 1999).

I think the best intervention should have been done a long time before I had ever met Joey. (Staff journal)

There were 16 boys and 13 girls in this sample with 17 children living in metropolitan areas and 12 in rural areas. Four children were Aboriginal. Although this sample was purposefully selected by clinicians to demonstrate their work, the client group described is generally representative of the overall Take Two client group for 2004 and 2005.

6.3 The family picture
Each story begins with the child's family picture in the form of a genogram. These genograms visually portray some of the complexities and changing relationships experienced by many of these families. They are often characterised by disrupted relationships, multiple partners and blended families. Although extended family members such as grandparents, aunts, uncles and cousins are not always directly involved with Take Two or with the broader system, these genograms provide a reminder of the child in context of multiple and multi-level relationships. This is particularly apparent when taking into account the stories of multigenerational abuse and trauma experienced in many of these families.

Following is the story of Tracey which begins many years before her birth and portrays the complexity of her family situation.

Tracey’s Story

Tracey’s Family

Amos
45 years

Carol
42 years

Terry
43 years

Ben
34 years

Monique
20 years

Antony
28 years

Jane
25 years

Tracey
1 year

Matthew
1 month

Tracey’s presentation to Take Two:
Tracey was 12 months old when referred to Take Two following hospitalisation due to a spiral fracture to her leg. Despite her young age, Tracey was described at time of referral to Take Two as showing major emotional difficulties, although there was little further information.

What happened to Tracey?
What happened to Tracey begins with understanding her mother’s, Monique’s traumatic history. Monique was placed in foster care at 12 months of age following sexual abuse by her step-father, Terry. In care Monique was subjected to physical and emotional abuse, including an incident where her head was held under water by the carer.

Soon after leaving the child protection system when she was 18 years old, Monique gave birth to Tracey following a difficult labour. Tracey’s father did not want a child and refused to provide support. Monique and Tracey went to live with Carol and Terry in an inner suburb of Melbourne and the sexual abuse towards Monique by Terry resumed. As a result, Monique became pregnant again and when Terry found out he made a failed attempt to abort the foetus in a physical assault. Tracey was present when this life-threatening assault to her mother occurred. Terry was subsequently imprisoned.

Shortly afterwards, Monique began a relationship with Antony, who assumed the role of father for the newborn child, Matthew. Soon after Matthew’s birth a notification was made to Child Protection regarding serious medical neglect and physical abuse of Tracey. Monique told workers that she only sought medical attention after a friend, who saw that Tracey was injured, threatened to contact the police if she did not take Tracey to hospital. The hospital assessed the injury as being days old and found Tracey covered in recent and old injuries, including bruises, cuts and abrasions. The injuries were assessed as being deliberately caused and Child Protection removed Tracey and placed her in foster care. Matthew was placed with a different foster carer; however, he and Tracey now live in the same placement with experienced foster carers.

What Take Two did:
At the time of referral to Take Two, Monique had regular access with Tracey through a Children’s Court order. The Take Two assessment demonstrated that Monique’s capacity to parent was limited: she showed little insight into parenting; was impulsive; and had great difficulty in regulating her own affect and emotions. She was unable to respond with empathy to either infant. This assessment in conjunction with work undertaken by Child Protection demonstrated to the Children’s Court that Monique was not in a position to safely resume the children’s care, but that she still needed to have an important role in her children’s lives. Following the assessment access was reduced to weekly contact where Monique attends playgroup with both Tracey and Matthew. This provides a more structured setting. The Take Two clinician has continued to work with Monique around these visits to assist her to develop more skills in relating to and caring for Tracey and Matthew. In particular Take Two is working with Monique to help her understand the children’s emotional needs and what they need from her.

Take Two commenced regular care team meetings with Child Protection, the foster care service and the foster carers. These meetings enabled the clinician to develop a comprehensive assessment of understanding of Tracey and to provide a more accurate picture of her functioning and responses to what she has already experienced in her young life. This collaboration and respectful information sharing also assisted the assessment of Monique’s parenting capacity and the implementation of appropriate recommendations to Child Protection.

The Take Two clinician began dyadic work with Tracey and Matthew’s foster carers, to assist them to form positive attachments and to develop their skills in addressing Tracey and
6.4 The children's presentations

The case studies provide a description of the children's presentation at the time of referral to Take Two. The children's externalising behaviours were often the focus as family, carers and workers felt overwhelmed and at a loss of what to do. Many of these behaviours were severe and included: arson; sexual offending towards younger children, children their own age and adults; physical assault; substance abuse; self-harming; sex working; indiscriminate and dangerous sexual activity; absconding; property damage; criminal activities such as theft; verbal aggression and threats; hurting or killing animals; oppositional and defiant behaviours; and high impulsivity and recklessness.

There were incidents where one or more of the children were so violent that the assaulted person (adults and children) was hospitalised. Some of the threats included raping younger children and killing others. Unlike the 'When Care is Not Enough' report (Morton, Clark, & Pead, 1999), these case studies were not selected to represent the 'highest risk' cases and reflect many similar scenarios within the broader Take Two client group.

There were also indications of some of the children's developmental, emotional and internalised behaviours. These included being withdrawn; low or negative self-esteem; unwillingness to talk about their past; few or no friendships; difficulties in concentrating and sustaining attention; outbursts of anger; developmental delays; eating difficulties; lack of self-care; enuresis; encopresis; educational delays; speech difficulties; difficulties in expressing emotions; lack of empathy; lack of trust in others; guarded and suspicious of others; sleep disturbance; hyperarousal; hypervigilance; and high levels of anxiety.

The problem with lists of externalising and internalising behaviours is that it is easy to lose a sense of who the child is amongst the litany of trauma and shame. Authors such as van der Kolk and McFarlane (1996) and Feiring, Taska, and Lewis (1996) have written of the pervasive problems experienced by children subject to abuse and neglect, particularly those associated with a sense of shame.

The question of shame is critical to understanding the lack of self-regulation in trauma victims and the capacity of abused persons to become abusers. Trauma is usually accompanied by intense feelings of humiliation; to feel threatened, helpless, and out of control is a vital attack on the capacity to be able to count on oneself. Shame is the emotion related to having let oneself down. (van der Kolk & McFarlane, 1996, p. 15)

Children are particularly vulnerable to traumatic events as their sense of self is developing on an incremental basis. Each new experience and the resultant emotional and behavioural responses build their sense of identity. For example, children are more likely to blame themselves for whatever happens, as the alternative would be worse; that is, to blame their parents (van der Kolk & McFarlane, 1996).

Many traumatized individuals, particularly children, tend to blame themselves for having been traumatized. Assuming responsibility for the trauma allows feelings of helplessness and vulnerability to be replaced with an illusion of potential control. (van der Kolk & McFarlane, 1996, p. 15)

A number of these emotional and behavioural difficulties directly impinge on the children's ability to form or sustain relationships with others, such as violence, lack of trust, few friendships and lack of empathy. This highlights the cascading effect of these difficulties that can exacerbate an already depleted network of supports and other resources. Many of the emotional and behavioural problems were described by Take Two clinicians in relation to younger children as well as high-risk adolescents.

In contrast, most of the children were also described as having personal or interpersonal strengths or resources. For example, some children were described as bright or intelligent. Some referrals noted that the children had periods of time when they were able to relate more positively to others. Others mentioned the child's ability to trust one or two people in their network, and that they had a certain level of emotional containment with particular adults. These adults included grandparents, step-parents, parents, teachers and adults in the community.

Diagnoses relating to these children either prior to or as a part of Take Two involvement included Attention Deficit Hyperactive Disorder, Depression, Posttraumatic Stress Disorder, Adjustment Disorder, Reactive Attachment Disorder, Oppositional Defiant Disorder and Conduct Disorder. Eight children (28%) had two diagnoses. A couple of children were described as having psychotic episodes. Cohen and colleagues (2000) and Perry (1999) stated that children with Posttraumatic Stress Disorder often have multiple diagnoses, such as Attention Deficit Hyperactivity Disorder, Depression and Conduct Disorder. This is
especially when they have been exposed to chronic trauma, such as child abuse.

Diagnoses provide a means of understanding symptom clusters within a broader assessment that can indicate particular therapeutic regimes. Take Two places more emphasis on the overall formulation than a specific diagnosis. Thereby Take Two aims to integrate an understanding of children in the context of their relationships, history and broader circumstances and to develop a hypothesis regarding the basis for their presentation in order to guide intervention planning.

One of the issues not commonly explored is the meaning this combination of diagnoses may have for the individual. It is probable that the whole is greater than the sum of its parts and so the various combinations of disorders could have more significant repercussions than what would be evident if responding to each disorder in isolation. Another reality for many children in the protection and care system is the combination of traumatisation with developmental delay or intellectual disability. This does not appear to have been explored within the trauma literature.

Many of these emotional and behavioural symptoms are similar to those reported for traumatised war veterans (Herman, 1992/1997). A number of these behaviours have now become part of the diagnostic criteria for Posttraumatic Stress Disorder, where those who have suffered a traumatic event show signs of hypervigilance, hyperarousal and avoidance that lead to impairment in their daily lives. The study of trauma begins with understanding how humans usually cope under threat in an adaptive way in order to maximise their chances of survival. Traumatisation occurs when these strategies either become maladaptive or are no longer available.

...changes in arousal, attention, perception, and emotion are normal, adaptive reactions. They mobilize the threatened person for strenuous action, either in battle or in flight. Traumatic reactions occur when action is of no avail. When neither resistance nor escape is possible, the human system of self-defense becomes overwhelmed and disorganized. Each component of the ordinary response to danger, having lost its utility, tends to persist in an altered and exaggerated state long after the actual danger is over. Traumatic events produce profound and lasting changes in physiological arousal, emotion, cognition, and memory. Moreover, traumatic events may sever these normally integrated functions from one another. (Herman, 1992/1997, p.34)

Over the last thirty years, as the study of trauma has more overtly considered the experiences of children, the developmental and family context has also been taken into account. Lieberman and Van Horn (2004) argued that emotional and behavioural symptoms must be understood in relation to the nature of the traumatic experience, the child’s temperament and constitution, the parent’s ability to respond effectively to the child and other protective and risk factors within the child’s family and broader environment.

A major complicating factor with the study of trauma has been the realisation that for many children and adults there is not one single event or even series of events, but rather a lifetime of destructive and overwhelming experiences. This chronic exposure to trauma is most likely to occur in the context of interpersonal and dependent relationships, such as young children exposed to child abuse and family violence (van der Kolk, 2001). This form of traumatic exposure and resultant symptoms is often referred to as complex trauma.

Our study confirms earlier investigations that have shown a relation between the age at onset of the trauma, the nature of the traumatic experience, and the complexity of clinical outcome. Subjects who had suffered interpersonal abuse at or before age 14 developed significantly more dissociative problems, as well as difficulties with modulating anger and self-destructive and suicidal behaviors, than either the older victims of interpersonal trauma or the victims of disaster. (van der Kolk, Pelcovitz, Roth, Mandel, McFarlane, & Herman, 1996, p. 89)

Herman (1992/1997) wrote that those who have been chronically traumatised no longer have a baseline of what is normal. Key features of complex trauma include more complicated and tenacious symptoms, major personality changes and greater vulnerability to further harm, both self-inflicted and as a result of the behaviour of others. This is consistent with an understanding of cumulative harm, where the focus is not only on the most recent traumatic event, but consideration of the chronic patterns of trauma and disrupted relationships that are evident for many of these children.

A theme in the case studies has been that the presenting issue is often more about the children’s behavioural difficulties than their experience of trauma. In some cases information about the child’s earlier experiences is unknown, while in others Child Protection has been involved since infancy. It appears that the older the child the greater the focus is on their behaviour and less is known or remembered about what has happened to them. This phenomenon is supported by analysis of the Harm Consequences Assessment data reported in Chapter 4.

6.5 Child protection and care involvement

The majority of the children were on Custody to Secretary or Guardianship orders (62%) with the remainder on interim orders at the time of referral. Consistent with the broader Take Two client group, many of the children experienced multiple episodes of Child Protection intervention. Figures 18 to 22 illustrate some of the children’s histories within the child protection system highlighting the different pathways that children may experience.

At the time of referral to Take Two, 25 children (86%) were placed in some form of out-of-home care, such as 13 were in home-based care; 4 were in kinship care; and 8 were in residential care. The remaining four were living with a parent at time of referral. The majority of children had experienced multiple placements ranging from two children each with 25 recorded placements, to one child who had never left his family’s care. The mean number of placements for the 29 children was eight.

One child had 6 placements in one year and another had 13 residential care placements in one year. These placement changes varied from being planned such as towards reunification or permanency or in response to a crisis or concern regarding the safety of the child in the current placement.

Sixteen (64%) of the children had experienced one or more reunification attempts prior to referral to Take Two. Two children had experienced four or more such attempts
at reunification, none of which were successful. Only two of these children were still living with their family after being reunited.

6.6 What happened to the children?

Trauma and attachment theories have informed the Take Two Practice Framework, particularly in its focus of understanding not ‘what is wrong with the child’ but ‘what has happened to the child’. Beginning with the referral process, Take Two asks referrers to record in the Harm Consequences Assessment what has happened to the child separately to how the child presents as a result of these experiences. The purpose of the Harm Consequences Assessment document is to provide a cumulative understanding of the child’s experience or trauma and deprivation in contrast to focusing on one or more episodes. From referral to closure, there is an emphasis on understanding the child’s experiences of trauma and relationships. For many it is not about discrete events but frequent or perpetual experiences of rejection, abuse, an absence of nurture and care and isolation. As such these children may not have a story to tell about their life, and yet are still trying to make sense of their experience and to survive as best they can. According to Meares (2002), one traumatic event is likely to be remembered, whereas recurring traumatic events are likely to be lost in a wordless fog.

As described in Chapter 4, most of the children involved in Take Two have experienced multiple forms of maltreatment over their young lives. All of the children in these case studies have multiple experiences of abuse, neglect and exposure to chaotic and dangerous situations such as family violence and parents with mental illness and/or substance abuse. The cases can be classified into two main types of experiences. The first group are those children who have experienced identifiable incidents of abuse and who may or may not also be living in a chaotic neglecting environment. The second group may not have a known history of abuse, but their story is nevertheless a familiar one. Their experience is of isolation, chaos, lack of attention and affection and a lack of insight into their developmental needs. They have often experienced harmful incidents, which are understood as part of life, such as accidents, ill-health, poor school achievement and no or minimal friendships. These children and those in their lives expect very little. Cumulative harm is a useful concept for understanding both of these classifications of experiences: that is where there are frequent incidents of abuse and/or where there is a sense of a never-ending absence of hope.

Cumulative harm refers to the accumulation of risk factors rather than focusing on each in isolation. Studies have found that additional risk factors contribute exponentially to the risk of mental health disorders, poor cognitive functioning, behavioural problems and poor school attainment (Appleyard, Egeland, van Dulmen & Sroufe, 2005; Mackner, Starr & Black, 1997; Kerry, Black & Krishnakumar, 2000). (Frederico, Jackson, & Jones, 2006, p. 4)

The following story about Emma illustrates the cascading effects of long-term abuse and neglect on a child.
Emma’s Story

Emma’s Family

Esme 79 years
Bobby (dec)

Wendy 31 years
Robert 55 years
Donna 34 years
Alice 40 years

Benji 14 years
Kim 7 years
Helen 17 years
Steve 20 years
Adrian 18 years
Emma 12 years

Emma’s presentation to Take Two:

Emma is a 12-year-old girl who has been a client of Child Protection off and on since infancy. She was referred to Take Two with concerns about her increasingly high-risk behaviours, inappropriate sexual behaviour, propositioning of men, aggression and violence, including bullying, property damage and following a number of attempts to injure her younger sister by trying to burn, drown and choke her. Emma has a history of fire-lighting, absconding and killing pets. Since her first placement at four years of age Emma has demonstrated longstanding behavioural and emotional difficulties.

What happened to Emma?

Emma has suffered a painful and prolonged history of abuse and neglect and intergenerational trauma. She grew up in an environment of family violence, chaos, unpredictability and transient accommodation. Emma was often left in the care of her older intellectually disabled sister, Helen, without adequate food or fluids. She suffered repeated physical, sexual and emotional abuse and witnessed the abuse of Helen. The home environment was marked with emotional and physical violence between parents and siblings. Emma was abandoned and rejected by her mother who overtly favoured her younger sister, Kim, and severely scapegoated and blamed Emma. Concerns of sexual abuse by male family members were raised since Emma was six years of age and substantiated after a disclosure when she was ten. Emma was placed in a residential unit when she was ten, after many placements. She does not reside in the same placement as her sister Kim, due to her serious violence and aggression toward the younger child.

Emma’s parents, overwhelmed by their own histories of abuse and neglect, were unable to protect and care for her or meet the developmental needs of their other children. Her father, Robert, was placed in care at six months of age while his mother recovered from serious illness, and at 13 he became a ward of the state. He spent time in out-of-home care and later in prison and psychiatric facilities. Emma’s parents met when Robert was 40 years old, and her mother, Wendy, was 16. Wendy also had been in out-of-home care where she was sexually abused. Wendy’s relationship with Robert was described as both a partner and father figure. They had three children including Emma and the siblings lived in a blended family with children from Robert’s other relationships.

Emma was described as hypervigilant, exceptionally well-tuned to others’ moods and behaviours and in a constant internal state of distress and confusion. Her history of chronic abuse and trauma leads Emma to interpret others’ behaviour through their non-verbal cues and based on her past experience of intense fear and helplessness. She has therefore learnt to respond aggressively, as if to protect and defend herself in order to survive. Her rapid shifts in emotion, from intense excitement to rage, and distrust of others are indicative of fears that the trauma will be repeated. Her disorganised and disturbed emotional and behavioural presentation meets the criteria for Posttraumatic Stress Disorder.

What Take Two did:

With such a traumatic past, substantial work was done by her Take Two clinician to engage Emma, establish a trusting relationship and create a safe and predictable space to explore her experiences. The residential staff described her as ‘blanking out’ and dissociating at times and the clinician witnessed this when Emma experienced significant emotional arousal. She refused to speak of her experiences and would become oppositional to requests and instructions, including refusing to complete any outcome measures. Emma refused to engage verbally saying that she was unable to discuss things that happened because her parents had told her not to. To avoid it she would divert to other themes and become aggressive and demanding. Unable to tolerate traditional talking methods, her weekly therapy sessions were spent in play, with the therapist interpreting her world through her behaviour and responses. Her play centred on re-enacting violence, abuse and trauma. In her games the victim of abuse was repeatedly subjected to humiliation, violence and denigration. Emma was unable to tolerate positive interactions or praise. Instead of accepting...
compliments she would abuse the clinician and demonise herself, often referring to herself as evil and bad.

The clinician met weekly with residential staff to enhance their understanding of Emma’s difficulties and support them in responding appropriately to her behaviour and psychological needs. Regular consultation occurred with Emma’s case manager to assist her in seeing Emma’s behaviours in the context of her traumatic past and to address her psychological needs. Emma experiences difficulties in concentrating and in taking in and comprehending information. Those involved in her care and education were advised to repeat information and verbalise at a simple and concrete level. Ongoing school intervention included fortnightly meetings with integration aides and teachers to assist them to develop education programs that would meet her learning and psychological needs and in managing her behaviour within the school. Take Two was required to give evidence during court proceedings regarding Emma’s emotional needs. Attempts to engage Emma’s family were unsuccessful.

**Emotional abuse:**

Nineteen of the 29 children (66%) experienced some form of emotional abuse, in addition to the emotional consequences of other forms of abuse such as physical and sexual abuse. Fifteen children (52%) also experienced some form of abandonment or rejection. This led to a combined 76 percent of the children experiencing emotional abuse and/or abandonment.

The most common emotionally abusive experience was overt rejection and feeling abandoned by one or both parents or carers. This occurred when parents placed their child with a family member, friend or stranger and did not return, or placed them frequently in foster care. It also occurred when parents did not attend access visits. Some children experienced a sense of abandonment when they were removed as a result of Child Protection and the Court’s decision-making and where the child felt let down by their parents’ lack of change, such as ongoing drug abuse.

> **Rejected children draw social maps in which they are insignificant specs or are surrounded by enemies, and these maps justify and encourage pre-emptive hostility.**
> (Garbarino, 1995, p. 90)

Many children experienced pervasive criticism, being scapegoated, an absence of boundaries between parent and child, manipulated within the family, humiliated, and being threatened not to tell others what is happening in the family. Some children were threatened with serious physical harm such as one child being told he would be thrown out of a window and another was warned that her mother would slit her throat.

Other frequently mentioned examples of emotional abuse were verbal abuse using demeaning, derogatory and sexualised language; and chaotic, uncaring, erratic and unpredictable care. One of the dilemmas is that many of these children are so accustomed to chaos and rejection that they appear resigned or even comfortable, but it is nonetheless harmful to their emotional wellbeing. A six-year-old who is told she is a ‘slut’ and needs to ‘shape up or get out’ has no measuring stick on self-worth or the worth of others.

**Outcomes:**

Emma responded well to the clear boundaries, consistency and stability offered by the residential unit, including the clear boundaries around her problematic sexual behaviour. Almost everyone involved with Emma has reported positive feedback since her involvement with Take Two. The changes noted by those involved have included a reduction in her sexualised behaviours, more impulse control, demonstrating a greater understanding of her emotions, and developing key relationships with workers in her life. The clinician believes that Emma will require long-term therapy considering the severity and pervasive nature of her difficulties. Take Two continues to work towards recommendations detailed in the initial assessment, in order to create an environment of safety, stability and security for Emma in which healing can occur.

**Physical abuse:**

In these case studies, 20 (70%) children experienced known physical abuse. Examples of such abuse included hitting and punching children; pushing a child’s face into the ground; throwing a child against a wall; hanging a child on a hook; stabbing a child with a knife; poisoning a child with adult medication; forcing a child to stand still for hours; children as young as one year of age being forced to drink alcohol; and frequent inappropriate discipline. Some of the resultant injuries included children being hospitalised in a coma, knife wounds, fractured bones, bruising and lacerations, life threatening brain injuries and multiple fractures. Although most of the physical abuse was caused by one or both parents or step-parents, there were also examples of physical abuse by older siblings and other family members.

All of these experiences had major psychological ramifications such as those indicative of torture or where children were living in fear of their own and their siblings’ lives. The previous evaluation report described some of the emotional, psychological and developmental consequences of physical abuse including heightened risk of mental health disorder, behavioural problems and difficulties in socialisation (Frederico, Jackson, & Black, 2005). There is also a growing amount of evidence regarding the physical impact of trauma on the neurobiological development of children (Perry, 2001; Shonkoff & Roberts, 2000). A primary issue for children is that trauma may not only affect the brain’s functioning, but also damage its potential for future growth and development. It may alter the child’s overall trajectory from the point of traumatic impact onwards (Perry, 2001).

**Neglect:**

Nineteen children (66%) were subject to episodic or chronic neglect, such as lack of supervision; chaotic environments where their needs were not met; inadequate food and fluids; not following through on medication; and inadequate stimulation. Seven children experienced periods of time where they were not fed. Five children were not given their medication or taken to see a doctor when
required. Three children were left in the dark or outside for long periods of time, including being locked in a cupboard or made to sleep with animals. Four children were not adequately supervised which placed them at risk of accident as well as indicating lost opportunities for stimulation and interaction. Some of these children were literally 'cold and hungry' and expected no one to pick them up and cuddle them or ask them about their day at school.

Recent studies have found that neglect, especially emotional neglect, can have more negative consequences than other forms of maltreatment (Dubowitz, Papas, Black, & Starr, 2002; Erickson & Egeland, 2002; Tomison & Tucci, 1997; Glaser, 2002).

_Neglected children brought to the attention of the Child Protective Services have a much higher probability of emotional, behavioral, cognitive, social and physical delays and dysfunction than "comparison" children._ (Perry & Pollard, 1997, p. 1)

Although neglect is not usually described as traumatic, it can be devastating to a child's wellbeing. Some forms of neglect such as emotional rejection and neglect leading to physical harm such as starvation or extreme isolation can constitute traumatic events. However, most neglect experienced by children who are clients of Child Protection is more likely to be epitomised by low impact, high frequency events where a specific event or series of events is not apparent. Rather it is a draining, cumulative and pervasive impact on the child that can affect all aspects of development and wellbeing (Frederico, Jackson, & Jones, 2006). From a therapeutic point of view, the challenge often entailed in working with neglected children is that the impact of neglect can impede the child's resources for growth and change. Examples include poor social skills, low self-esteem, passivity, limited communication, impoverished access to internal and social resources and a lack of expectation that adults will care enough to do anything different (Erickson & Egeland, 2002).

_Neglected children, if they survive physically, often fail to develop the confidence, concentration, and social skills that would enable them to succeed in school and in relationships. The behavior they bring to the classroom sets them up for a continuing cycle of failure and disappointment unless something happens to make a difference._ (Erickson & Egeland, 2002, p. 14)

Wark, Kruczek, and Boley (2003) have shown a link between emotional neglect and suicidal ideation and self-harming behaviours. Other behaviours indicating emotional concerns include self-soothing or self-stimulating behaviours such as rocking and odd eating behaviours (Wark, Kruczek, & Boley, 2003; Watson, 2005).

**Sexual abuse:**

Six (21%) children had experienced sexual abuse, ranging from abuse by parents or parent figures, siblings, extended family members, family friends, other children in the community and strangers. Workers had concerns regarding possible sexual abuse for another seven children, based on the children’s exposure to known sexual offenders and their own sexualised behaviours. The impact of sexual abuse is well documented in the literature and is often described as traumatic and associated with a range of mental health and behavioural problems (Kendall-Tackett, Williams, & Finkelhor, 1993; Putnam, 2003).

**Exposure to family violence:**

Twenty children (70%) had direct exposure to serious or extreme family violence. Such violence included attempted murder, setting people on fire, stabbing, rape and pushing and punching. For some children, each of mother's partners brought a new arsenal of violence to the home. One child was forced to watch when his father brought him into the room so that he could see what happens when someone does the wrong thing. Fourteen of these children had overtly aggressive or violent behaviours towards others.

The concomitant experiences associated with family violence include fear and intimidation in the home, a domineering environment and loud and unexpected noises. Some of this violence occurred whilst the couple were together and some occurred post-separation, highlighting that for some children there was no end in sight. For example, one father stalked the mother over many years. This is consistent with research showing that post-separation violence is a major issue for many women and their children (Humphreys & Thiara, 2003). A four-year-old sitting in a room whilst the adults are screaming abuse at each other and him, dissolving into tears, and waiting for the sign to hide or run or protect his mother or siblings is not having a childhood.

**Exposure to other violence:**

Five children directly witnessed their father or mother being violent to others in the community. For example, one child witnessed her mother tearing the hair out of a neighbour's head, another parent stabbed a neighbour and another child witnessed his father in a violent police siege. Garbarino and Kostelný (1996) described similar scenarios of family and community violence as akin to war zones. It reinforced the findings that many of these children experienced a similar psychological impact as war veterans, though often more insidious.

**Impact of poverty:**

Ten children were reportedly affected by poverty, the most common indicator of which was homelessness, eviction and transience. Some were described as being in overcrowded and stressful living environments. Most of their parents were unemployed and had ongoing or intermittent financial problems.

Issues of poverty and the associated difficulties are often taken as a given for children involved in child protection (Glaser, 2000), yet for the children it can add to their sense of low worth and disconnection from the community. It is therefore possible that poverty was an issue for most of these families but only mentioned in relation to issues such as homelessness. Poverty further depletes families’ access to resources. This is even more apparent for those living in rural areas where access to public services is often restricted. Parton (1995) wrote about the association between child maltreatment and social ecology, such as poverty, economic marginalisation, unemployment and chaotic neighbourhoods.

**Parents with mental illness:**

The majority of these children (70%) had one or more parents or parent figures with a serious mental illness or personality disorder such as Schizophrenia, Depression or Borderline Personality Disorder. What this meant for the
Parents with substance abuse problems:

Twenty children (70%) had at least one parent with major substance abuse problems including chroming, marijuana, amphetamines, heroin use, misuse of prescribed medication and alcohol abuse. Nine children had two parents or parent figures abusing alcohol or drugs. Fifteen children experienced exposure to both parental substance abuse and family violence. Similarly, fifteen children experienced both exposure to their parents’ substance abuse and mental illness. Twelve children experienced all three types of exposure. This combination of issues relating to parental mental illness, substance abuse, and exposure to family violence is consistent with findings from the ‘Integrated Strategy Report’ (DHS, 2002).

Substance abuse may be a causal factor leading to abuse or neglect. It can also lead to a high level of chaos, uncertainty and the potential for exposure to other traumas, such as finding a parent overdosed or having car accidents through drinking and driving. One of these children witnessed her mother’s overdose and subsequent hospitalisation.

The data show that, in 2000-01, of parents involved in substantiated cases of child abuse or neglect, about a third had problems with alcohol abuse, a third had substance abuse problems ... All of these factors have increased over the past five years, in particular the number of parents with substance abuse problems and parents with a psychiatric disability. Many parents will have more than one of these problems. (DHS, 2002, p. 27)


Child’s experience of loss, grief and separation:

Five children had experienced the death of a parent. Although the cause of death was not always known to Take Two, one was due to a heroin overdose and one was due to cancer. Another experience of separation and loss for many of these children was when a parent was incarcerated. Fourteen children (48%) had a parent in gaol at some time or another and one child had both parents in gaol. As with a parent’s death, these children were not always sure whether they felt sad or relieved when an abusive parent was no longer living in the home; however, this appeared to lead to a sense of further shame for the child on some occasions. Complex forms of grief such as the death or long-term incarceration of an abusive parent can have additional implications for children (Fearon & Mansell, 2001; Pynoos & Nader, 1990; and Pynoos, 1992). Lieberman and Van Horn (2004) wrote that the loss of a parent or parent figure is a traumatic experience for young children given their lack of emotional and cognitive maturity to cope with major loss without disruption to their continuity of their sense of self. They recommend that both trauma theory and loss and grief approaches should be utilised in understanding children’s experiences of significant loss.

With a single exception, these children had at least one experience of being removed from their parents and again this sometimes brought a mixture of emotions. However, the impact on the children’s attachment relationships was not always clear. As indicated earlier, some of these children experienced as many as 25 placement changes along with the concomitant changes in schools, friendship networks and other key relationships. This coupled with their experiences of reunification attempts which were not sustained illustrates the additional losses that children can experience in the protection and care system.

Six of the twenty children who were old enough experienced admission into Secure Welfare, inpatient treatment and/or Youth Justice centres. At least two children had experienced periods of time of separation as a young baby due to medical illness.

For many children their placements involved separation from siblings and for some complete loss of contact with siblings and other family members.

Intergenerational trauma:

There was information that at least 16 of these children (55%) were impacted by major intergenerational trauma. This included parents and other family members being sexually abused, placed in care, physically abused, neglected, a witness to violent crime by family members, immigration and refugees and being a part of the stolen generation. The impact of the parent’s own experience of trauma was often known by the system, but was difficult to take into account when planning how to work with the family and what was reasonable to expect. There was also the parent’s trauma associated with the child’s experience and their experience of parenthood. For example, one parent was told that her baby would die due to a congenital medical problem. Other parents were extremely distressed and felt powerless and ashamed when their children were sexually abused or in other ways harmed.

Positive experiences:

In 14 cases a positive experience or context was noted in the referral document or staff journal. In 12 instances the presence of someone in the child’s network who was committed to them, such as their mother, grandparents or teachers, was described. Schools were mentioned as a positive and committed presence in the child’s life in six cases even when the school was bearing some of the brunt of the child’s violence. In another six cases the child’s carer was described as a major positive support in the child’s life.

6.7 How does Take Two intervene?

The cases illustrate the diversity of interventions utilised by Take Two, often in collaboration with other services. Interventions were based upon the needs of the child, the goals of the referrer and ensuring developmentally appropriate and culturally respectful practice. The interventions were also guided by theory, particularly in...
relation to trauma and attachment. Although this analysis presents the stories in a linear fashion, the reality is different. Assessment and engagement often work together and alternate as to which takes precedence. These are interspersed with direct intervention and vice versa. Systems intervention may begin before the referral through consultations and the referral process itself, but is also a common thread throughout Take Two’s involvement.

For example, although it was not a question in the staff’s journals 14 commented on what was their first step or priority for intervention. Five identified that the first priority was to develop a therapeutic relationship or direct engagement towards trust with the child. Four journals stated that the initial step was to work with the parent or carer as, until they were feeling more supported and in control, it would not be helpful to see the child individually. Others focused on working with the professionals involved to ensure that they were all following the same approach. Another wrote of the need to first structure how Take Two was going to work within the team to respond to a complex case. Assessment was often mentioned as a core component of the above-mentioned strategies.

Sammy’s story provides an example of how Take Two worked with an Aboriginal child with an extensive background of abuse. In particular it illustrates some of the strategies used to engage Sammy and his family, not only with Take Two but with the residential care service.

Sammy’s Story

Sammy’s Family

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joan (dec)</td>
<td></td>
</tr>
<tr>
<td>Jack</td>
<td>58 years</td>
</tr>
<tr>
<td>Bruce</td>
<td>37 years</td>
</tr>
<tr>
<td>Faye</td>
<td>36 years</td>
</tr>
<tr>
<td>Ray</td>
<td>35 years</td>
</tr>
<tr>
<td>Vivien</td>
<td>34 years</td>
</tr>
<tr>
<td>Charlie</td>
<td>32 years</td>
</tr>
<tr>
<td>Felicity</td>
<td>20 years</td>
</tr>
<tr>
<td>Kevin</td>
<td>18 years</td>
</tr>
<tr>
<td>Paul</td>
<td>17 years</td>
</tr>
<tr>
<td>Tom</td>
<td>14 years</td>
</tr>
<tr>
<td>Sammy</td>
<td>12 years</td>
</tr>
</tbody>
</table>

Sammy’s presentation to Take Two:

Sammy is a 12-year-old Aboriginal boy who lives in a residential placement. Concerns raised in the referral to Take Two about Sammy’s behaviour included arson; absconding regularly from placement and school; and showing reckless and dangerous behaviours, such as climbing on car roofs. Sammy came to Take Two with a diagnosis of Attention Deficit Hyperactive Disorder and was on high dosages of medication. He had been assessed with borderline intelligence and demonstrated educational delays of approximately two years behind his age.

What happened to Sammy?

Sammy was first removed from his parents’ care at the age of four years after he had been severely physically assaulted by his father, Charlie, and suffered a fractured skull. During hospitalisation evidence of other injuries was found, demonstrating a history of life-threatening physical abuse. Sammy and his two older brothers were placed in the care of his Aunt Faye and Uncle Bruce on Custody to Secretary orders. They continued to have frequent contact with their father, as he lived in the same street. Over the next seven years they were often left in Charlie’s care. A couple of reunification attempts occurred when Sammy was aged between five and seven years. Each of these broke down following concerns regarding Charlie’s substance abuse and his mother Vivien’s, mental health problems. Charlie has long-term problems with chroming and marijuana abuse. Vivien suffered depression and her whereabouts have been unknown since Sammy was eight years old.

At 11 years of age Sammy was removed from his aunt and uncle’s care due to concerns of ongoing emotional rejection, scapegoating and constant criticism proving to him he could never do anything right. Child Protection assessed that his aunt and uncle lacked understanding of Sammy’s needs and were unable to manage his increasingly violent and high risk behaviours. Sammy had a seriously disrupted education and long periods of non-attendance.
What Take Two did:

A core issue identified on referral to Take Two was the imperative to undertake interventions from a culturally respectful perspective and therefore Sammy was allocated to the Aboriginal team. The Take Two Aboriginal clinician met regularly with Sammy in a range of settings, with a focus on engaging him and helping him to develop trust in the clinician. One of the strategies the Aboriginal clinician used was to take Sammy on drives with him, which encouraged him to be more open to talking, as the emphasis was not on eye to eye contact. The direct contact with Sammy enabled Take Two to formulate an assessment of his developmental and emotional needs. The primary goals of Take Two's intervention were to address Sammy's experiences of loss, grief, rejection and abandonment and to assist those working, living and relating to Sammy to be more responsive to his needs. The Aboriginal team provided Sammy with an opportunity to have a positive cultural role model. His clinician met with his previous carers Aunt Faye and Uncle Bruce regularly to support them and enhance their understanding of and ability to meet Sammy's emotional needs. The case plan was aimed at their resuming Sammy's care in a safe and nurturing way. For example, one strategy was to advocate for the family to be more actively involved in Sammy's placement and at school. Shared lunches in the residential unit became a regular event. These lunches enabled Sammy to see his aunt, uncle, father and brothers interacting with his carers. This had the added value of getting the people in his life to work together more effectively. The lunches assisted his aunt and uncle to realise that their care-giving approach in the past had been problematic and that the problems did not rest solely with Sammy and his behaviour, nor the earlier abuse. As a result, they were able to commit to working on their own parenting and to have regular contact with Sammy, in order to have him return to their care. The Aboriginal clinician provided ongoing consultation and cultural awareness to the residential staff. The clinician advocated for a more culturally appropriate placement, which has since occurred. Take Two worked closely with the school to plan for Sammy's re-integration into the school environment and routine, including strategies for increasing hours and expected attendance. Take Two was also successful in advocating for an integration aide. Through advocacy the Aboriginal clinician brought Sammy's family, carers, Child Protection workers, doctors and the school together, to prevent splitting and to enable them to learn from and support each other. Another recommendation of Take Two was for the level of medication Sammy was receiving to be reviewed and if possible reduced. This has subsequently occurred to great effect. Outcomes:

Some of the positive changes for Sammy since Take Two involvement have included: Sammy's father decreased his substance usage especially around access visits; Sammy's increased and more positive contact with his family; Sammy attending school more regularly; Sammy's family becoming actively involved in his placement and schooling; and the residential placement opening up to the family being involved in Sammy's routine. Sammy has changed markedly, and has gone from rarely talking to anyone to a willingness to talk about things that interest him. He is involved in sport and recreational activities, and his criminal and other at-risk behaviours have ceased. Sammy has developed a sense of right and wrong and is for the first time experiencing respect from others. As such he has a growing network of friends.

6.7.1 Assessment

Assessment was regularly raised as one of the goals at time of referral either in relation to the children, their current or prospective placement or both. Assessment of a child who is traumatised by maltreatment and/or suffering disrupted attachment is complex. An overriding factor is to consider the safety of the child prior to initiating intensive therapeutic intervention. Even when children are removed from the context of abusive family environments, the previous chapter highlighted that a considerable number of children continue to be at risk either from their families, within their placement or in the general community. Hence Take Two clinicians have to be mindful of this as they undertake assessment and intervention with the child, their family and with carers.

The foci of assessments were primarily on the children's emotional, psychological and developmental wellbeing and in the context of their key relationships with parents, carers or both. Assessments also incorporated children's broader social networks such as peer groups and how they functioned in different settings such as at school. Some referrals requested Take Two to undertake assessments to provide specific information, such as about the parent's ability to meet the child's emotional needs or a mental health assessment. The process of assessment included direct observation of the children on their own and in interactions with others, such as family visits and observing access parents. Assessment also included meeting with parents, carers and other workers and undertaking detailed file reviews.

Following is an example of some of the goals that were formed following an assessment of a 14-year-old girl.

*For Anne to be engaged in individual work that aims to:*

- assist her in understanding and integrating her past experiences of trauma and to begin to make sense of how these experiences continue to impact upon her, and
- reduce her negative self-concept and inner shame and promote a more healthy sense of self.

**Ongoing consultation to be offered to residential unit staff to:**

- support them in understanding the impact of trauma upon Anne's presenting behaviours and relational style,
- develop ways of relating to Anne that do not reinforce her beliefs that she is unlikable and intolerable, and
- develop strategies that contain Anne and create a sense of safety.

6.7.2 Establishing care teams

A common first intervention is assessing and working with the child's formal and informal networks. This is essential if the clinician is to be assured that the child is in a safe place as this informs how to approach therapy without inadvertently increasing the risk to the child. The building of care teams to facilitate this work has become an important part of Take Two’s work. Working collaboratively with,
supporting and/or educating carers and members of the service system is a core intervention.

Care teams were mentioned explicitly in 18 of the 29 case studies and were inferred in most of the remaining studies. The frequency of meetings varied weekly to every eight weeks. Most meetings were face to face, but some were primarily by phone, such as when key professionals or family members were from other parts of Victoria. They varied as to whom participated, but invariably included the case managers from either Child Protection or the Community Service Organisation. They usually involved carers and schools. Other people who sometimes participated were parents, paediatricians, preschools and housing workers. Although all of the care teams mentioned in these case studies were initiated by Take Two, there were at least two where other services took over the facilitator role. For example, in one case the Take Two Secure Welfare Senior Clinician initiated the care team approach. He attended the first few meetings of the care team before discontinuing due to the short-term nature of his role. In another case, the school's enthusiasm for the task made them the obvious choice to ensure the meetings continued.

The following are quotes from staff journals highlighting various goals of care teams.

Assisting the care team to adopt and maintain a 'therapeutic attitude' in working with this child. (Staff journal)

That regular care-team meetings facilitate a shared understanding of her and a shared and consistent approach. (Staff journal)

The care team has a greater recognition and understanding of how Jeremy's inner world is expressed in his behaviours and relating style. (Staff journal)

6.7.3 Engagement - Developing a therapeutic relationship

Parallel to this work with parents, carers and/or service system, an initial and ongoing task is the building of trust between the clinician and the child. Clinicians recognise that the child has often learnt not to trust adults. Moreover, if the child was in an unsafe situation this had to be dealt with in partnership with the other services involved. This work includes assessment of and/or support for the parent's or carer's ability to respond appropriately to the child.

Approaches to build trust with the child included play, psycho-education, allowing the child personal space such as driving in a car together or meeting at neutral places (for example a café or park) where the child feels more comfortable. Other strategies included use of metaphors that the child could readily respond to, such as sport or television shows. Building trust usually takes a long time which is to be expected for children whose trust has been abused by adults for much of their lives. For example, one child made it clear that it would take time for him to trust the clinician.

Slowly she began to settle into the sessions and after realising that I wasn't going away even after she was 'horrible' to me, she began to engage at a deeper level and talk for short stints about her history. (Staff journal)

The length of time to build trust is illustrated in the following example: An 11-year-old boy could not tolerate any talk in therapeutic sessions for almost two years. He would play silently and silence the therapist's interpretations. His ability to engage in therapy developed over time as a care team was put in place, the placement changed and he had more understanding carers who were supported by the clinician. Thus, the clinician needed to work with the child's informal and service system and develop a care team before therapy could be effective.

Another example was in relation to a young Aboriginal woman who frequently disappeared from the residential unit whenever the Take Two clinician was expected. In consultation with the Aboriginal team, the regional clinician continued to visit weekly and always left her card saying that she had missed seeing the young woman. Meanwhile the Aboriginal clinician began to work directly with the young woman's mother, eventually piquing the young woman's interest as to why her mother was so involved. This young woman began to reach out to the Take Two clinician who was still visiting every week and has since included her in her life, including relying on her for intensive support during a medical crisis.

It has been extremely important ...to build a relationship and a sense of safety in a very slow and gentle way. (Staff journal)

For another child, engagement was a primary goal as this child had never previously engaged with a therapist and in fact had threatened many of them. A different child continued to resist the clinician's attempts at individual therapy and so after trying various strategies the clinician changed approach and worked with the family as a whole for a period of months. At a later time, when the child was more responsive and self-aware of some of her own fears, individual work was able to resume.

Clients of particular teams such as Secure Welfare and the Aboriginal team require different approaches to engagement and intervention. The Aboriginal team use a culturally informed approach to engage the young person and the community. The approach to a holistic intervention utilised by the Aboriginal team is seen in the previous case study where the Aboriginal clinician's work with the residential workers helped to establish a consistent approach around the child and increase the child's sense of safety and stability.

In Secure Welfare the engagement is necessarily brief. The impact of this as an effective intervention is demonstrated in the case of Victoria. Victoria's story demonstrates the strategic use of a short-term contact over time which facilitated her engaging in the intervention.
Victoria’s presentation to Take Two:

Victoria is a 16-year-old young woman who was referred to Take Two Secure Welfare with a history of high risk behaviours including an extensive history of substance use, absconding from placement, volatile and aggressive behaviour and self-harming. Her lifestyle and behaviours placed her in a situation of chronic risk, with the risk of death by misadventure and safety concerns on a daily basis. Victoria was on a Guardianship order and was on the Child Protection high risk client register. Due to Victoria’s high risk behaviours and concerns relating to her use of heroin and possible sex working, she was admitted to the Secure Welfare Service for two admissions (one month apart) following indications of acute risk, with a third admission some months later.

What happened to Victoria?

Victoria is the youngest child of Bev and Laurie. Bev suffered noticeable mental health difficulties when her children were toddlers. Bev’s mother, Daphne, was described as having long-term alcohol problems who abused medication, suffered mental health issues and left her family when Bev was six years old. Bev and her two siblings were raised by their father, who was physically abusive, domineering and very critical of Bev. Bev left home at 16 and was homeless for some time, which also marked an end to her schooling.

When Victoria and her siblings were toddlers Bev was admitted to hospital as an involuntary mental health patient. As a consequence of her inability to comply with treatment recommendations she was subject to Community Treatment Orders. Numerous notifications were made to Child Protection throughout Victoria’s life. These centred on Victoria’s exposure to her mother’s mental health difficulties and subsequent physical and emotional abuse and neglect. Child Protection became involved when Victoria was three-years-old. Bev was largely unable to resolve protective concerns due to her substance misuse and inability to engage in psychiatric treatment. Victoria witnessed violence between her grandfather and mother; was subjected to repeated verbal and physical abuse from her mother; and physical abuse from her brother Owen.

Victoria was first placed in out-of-home care at age eight, and reports of her emotional and behavioural disturbance were evident then. She suffered numerous separations from her mother and siblings. While she appeared to feel safer away from her mother’s frightening behaviour, Victoria was distressed by the separation. This was compounded by sadness and anger that her mother had not addressed the protective concerns that would have enabled her to return to her care and feeling abandoned and rejected.

When Victoria was 11 years old, behavioural problems began to emerge and patterns of absconding became more entrenched. At 13 years of age her difficulties escalated. Victoria experienced six placement changes in a year, was placed in residential care, expelled from school and her relationships with family severed. She said that she did not wish to live with family members and her behaviours further deteriorated. This included continual absconding, property damage, physical assault and threats to staff and residents, escalating substance use and other dangerous behaviours. Victoria was admitted to Adolescent Inpatient Units following incidents of self-harming, suicidal ideation and auditory hallucinations.

Victoria’s experiences of multiple placements, abandonment and rejection by family and exposure to her mother’s frightening behaviours have taught her that she cannot trust anyone. Her chronic use of substances represents the most effective, albeit harmful strategy that Victoria could find to manage the impact of trauma. Victoria does not have the capacity to look after herself, to regulate her behaviour or emotions or to cope with more independent placement option.
What Take Two did:
On Victoria’s first admission to Secure Welfare she had a very difficult time as she was withdrawing from heroin and experienced severe hyperarousal, anxiety, sleep disturbance and affective instability. Due to the heroin withdrawal Victoria could not engage with support workers or staff. On her second admission she was medically supported to manage her withdrawal and this assisted her to cope better with the effects. During this second admission Victoria engaged with the Take Two Secure Welfare Senior Clinician and began to develop a relationship. During this engagement she learnt that she could trust the clinician and had a positive experience with mental health services. This was of critical importance given Victoria’s history of not engaging with services and workers. She appeared to benefit from the sense of containment and safety provided by the Secure Welfare Service admission. However, she still found it very difficult as she could not use the usual strategies she used to deal with overwhelming affect, such as drug abuse.

Take Two conducted an assessment including a mental health status assessment and provided recommendations in relation to acute and chronic risk and minimising harm in relation to Victoria’s lifestyle. Take Two also provided consultation to the system focusing on crisis management. This included contextualising crisis times, such as pending court issues and absconding from the residential unit. A set of guidelines for conditions that warranted an admission to Secure Welfare was developed, and these were made clear to Victoria. A strategy of two short stays was planned, with the arrangement for the Take Two Secure Welfare Senior Clinician to be engaged.

Outcomes:
The Take Two Secure Welfare Senior Clinician continued to have contact with Victoria by telephone, outside of her admission times into Secure Welfare. Consultation to the system supporting Victoria also continued. It has been eight months since Victoria’s first Secure Welfare admission and she has not used heroin since. She has continued to take prescribed medication to help contain her hyperarousal, anxiety and agitation and has ceased sex working. When Victoria has periods of absence from the residential unit she remains in contact with the staff and she has not assaulted staff or damaged property at the unit. Over the last six months Victoria has been relatively stable, with two short Secure Welfare admissions. She has been attending day programs and is making and keeping appointments with workers.

6.7.4 Diversity of interventions
As described in the previous chapter, interventions undertaken by Take Two clinicians are diverse. Eighteen of the case studies made reference to individual work with the child with another two showing work with the child and their parents together. All but one of the remaining nine cases involved the child in the assessment process. However, most of the intervention in these eight cases was focused on the parents, carers or systems to strengthen their ability to understand the children’s inner world in order to better meet their needs.

I think that the major success in this situation was our opportunity to engage and prepare working with the mother in the first instance in order to make for increased success and sustainability for the children over time. (Staff journal)

The partnership with the clinician assisted the carer in perceiving Gerald in a more balanced way, reduced her sense of isolation and improved the attachment and affection between them. (Staff journal)

An individual therapy approach mentioned in ten cases was the use of play therapy and other non-structured or semi-structured approaches. These approaches, based largely on psychodynamic theories, enable children to explore their feelings, thoughts and beliefs through play or storytelling. Much of trauma theory emphasises the importance of the clients learning to understand what has happened to them and being able to explain it, at least to themselves, in a meaningful and non-terrorising way. Children who are developmentally or functionally unable to verbally tell others or reflect on their own thinking can explore their reactions through play.

Traumatized people relive the moment of trauma not only in their thoughts and dreams but also in their actions. The reenactment of traumatic scenes is most apparent in the repetitive play of children. (Herman, 1992/1997, p. 39)

Play therapy often entailed the child using the toys and equipment available, while the clinician varied between direct interaction and a more passive style. The clinician looked for potential themes arising from the play that helped them to understand the child’s internal world. Some gently explored their own thoughts with the child to see if they made a connection or provided a mirror to the child of what is happening in the therapy session. For example, in some cases the clinician repeated out loud some of the themes that came up in an unstructured play session or suggested a particular game that was likely to raise some of the issues that the child was dealing with in real life.

While he has been reluctant to talk verbally about his experiences, he has communicated in play therapy much of his fear and his confusion. (Staff journal)

Two journals mentioned Cognitive Behavioural Therapy and another mentioned psycho-education with the child. This is described in Chapter 5 as providing a more structured approach to achieve similar goals to the more unstructured approaches listed above. CBT is considered more appropriate when a child can ‘tolerate’ talking about their experiences and behaviours directly.

Seventeen cases made reference to work with parents or carers, mostly in conjunction with the child, but sometimes as child-focused therapy. The following is a detailed quote from a staff journal highlighting the combination of approaches with various members of the family.

This individual therapy [with Genie and Peta’s mother] continued focusing on developing child focused parent therapy aimed at developing her relationships with each daughter, addressing traumatic triggers and those childhood experiences that impacted her children and developing her knowledge of the children’s emotional and developmental needs… [Two clinicians] facilitated eight weeks of parent - child therapy [with each child separately.] These interventions were designed to develop the security of the children’s attachment to assist mum learn play and
communication skills with her children and to minimise the tendency for either child to be scapegoated by mum. These sessions were followed with four home based sessions of family play therapy (including mum, both children and an older sister when she was home on access). The aim of this intervention was to assist [their sister] feeling included in this intervention, reduce the rivalry between siblings and assist mum to transfer her developing skills back into the home. (Staff journal)

6.7.5 Systems interventions

Many of these therapeutic interventions are only possible in partnership with other services. These include Child Protection or Community Service Organisation providing effective case management; the Community Service Organisation supporting the carer; the school meeting the child's daily needs for both learning and social interaction; and other services such as CAMHS, family services and Aboriginal services. Take Two's role in this service system is often to help others understand the child's inner world and to enable the system to focus on 'keeping the child in mind.'

Systems interventions were mentioned in 22 case studies with 13 specific references to work with schools. The majority of Take Two cases involve a combination of child, family and systems intervention.

Systems work is vital - but it is never one thing - maybe just the first thing. It is never one thing but a combination of interventions. It's a juggling act sometimes. (Staff journal)

6.7.6 Case closure

How a service completes its work with a vulnerable child and family is often a difficult task. When a child has finally formed a trusting therapeutic relationship and has been able to use the therapeutic process to achieve positive change, a misstep of timing or process around closure can be destabilising. The same can be said for closure with parents and carers.

Celebrating milestones and achievements; using review processes to work towards a time when the service is no longer involved; making recommendations regarding referrals to other services; gradually reducing contact; and providing useful reports to case managers and other services are all strategies for successful closure. These processes can be truncated when closure is due to other factors, such as when the child or family leaves the state or Child Protection ceases its role.

A difficult aspect of closure is determining when the work has been completed. Much of these children's process of recovery will take many years and yet they do not necessarily need to be in therapy throughout this time. Another confounding issue is to distinguish between when the improvement of a child's situation or symptoms is an indicator that closure is appropriate or when is it an indicator that the work is on the right path and more is required.

The case studies have highlighted examples of these and other dilemmas in preparing for closure. Ten cases had either closed or were in closure phase at the time of writing the staff journal. For example, in the case of Shane that is discussed later in the chapter it was considered appropriate for Take Two to close once the core goals were achieved and plans were underway for alternate ongoing support. In another case, although significant progress had been made, it was agreed by all involved that Take Two needed to continue. The alternative would have represented a failure of trust to both the child and carers who remained anxious at their ability to sustain the care needed for the child. In some situations, although closure is appropriate, there remain concerns regarding the timing.

While the child's situation had certainly improved to a point where [closure] was appropriate, it was also at a time when he had started to engage enough to start talking about his worries. (Staff journal)

In two cases, clinicians mentioned the progress the children had made at school after a lengthy history of school disruptions. In these cases it was considered important for Take Two to remain involved in order to assist in the imminent transition from Primary School to Secondary School. In two other cases concerns regarding other services' waiting lists were mentioned. Closure is a prime example of the importance of the care team which hopefully continues post Take Two involvement and can support the child and family and his or her immediate and broader system.

6.8 Case study outcomes

This next case vignette tells the narrative of a family with the focus on three children. The case highlights the importance of attention to each child in the family alongside the need to work with the whole family. It describes a range of positive outcomes witnessed by those involved.
A Family's Story

Justin, Ellie and Xavier's Family

Children's presentation:

Louise has five children from four relationships. It is the three youngest who are clients of Take Two.

Justin

Justin is an 11-year-old boy, who presented to Take Two with serious sexualised behaviour and offending, sleep disturbance, absconding, conduct problems, severe alterations in affect, a disturbed sense of self, social isolation, self-harm, and verbal threats of suicide. He has an intellectual disability. In his sessions at Take Two Justin would try to assert control, refusing to answer questions or complete tasks, and use repetitive play to manage his anxiety. Justin made provocative comments to test the reaction of the clinician. He recognised that people were scared of him and became angry at times, gritting his teeth and tightening his body. He presented as very distressed and would cling to any perceived protective adult. He was highly anxious and disorganised in his relating to others, sometimes seeking closeness and other times withdrawing from them in fear.

Ellie

Ellie is a five-year-old girl referred to Take Two because of concerns regarding her challenging and aggressive behaviour towards others. It was reported that Ellie was defiant, stubborn, argumentative, fought for control, was aggressive, swore, hit and spat at others. Often Ellie presented as emotionally detached and subdued. She sought attention from men in particular. Ellie presented as bright, articulate and readily engaged with others. She preferred adult company and was indiscriminate in her communication with others. Her aloof and seemingly uncaring manner made it difficult for her foster carers to believe she was forming an attachment with them. As a result of her early attachment difficulties and loss and grief, Ellie assumed an adult role and sought to control situations. She consequently became defiant and aggressive when others tried to set limits. Ellie’s placement with her first foster carer ended, reportedly due to her challenging behaviours.

Xavier

Xavier is a three-year-old boy who was described as an ‘unhappy’ child, who did not smile or engage, and he presented as withdrawn. His father died when he was one year of age and his mother has experienced ongoing depression. Xavier presents as a boy who is withdrawn and makes limited demands.

What happened to this family?

The children’s mother, Louise, has a history of exposure to violence, rejection, loss and abandonment as a child and adult. Her father was a heavy drinker and was verbally and physically violent to her mother, Anne, and Louise. When her mother left the family Louise was raised by her father, until she was 16. At this time she went to live with her mother, despite years without contact.

Shortly after returning to live with her mother, Louise became pregnant with twins at 17 years of age. Following the twins birth Anne helped Louise with the care of the babies. Eventually Anne assumed the full-time care of Lisa and Ewan. According to Louise she felt tricked into leaving Lisa and Ewan in her mother’s care. Soon after, Louise gave birth to Justin. She separated from Justin’s father, Garry, seven weeks after the birth, leaving a relationship marked by family violence. Louise has reported serious family violence from all her partners, including episodes
that resulted in serious injury. Louise has experienced several losses throughout her life, including the abandonment by her mother, the death of her partner (Ellie’s father) and the relinquishment of her twins to her mother’s care. Louise has suffered serious depression and acknowledges that she needs ongoing treatment for her mental illness.

Justin, Ellie, and Xavier have a history of exposure to family violence and neglect. Their homes prior to removal by Child Protection were marked by chaos and parental drug and alcohol use. The children have experienced an uncertain, erratic and unpredictable relationship with their mother, and have had lengthy periods without contact whilst in out-of-home care. All three children have suffered serious loss and grief with the death of Ellie’s father.

Ellie and Xavier were removed from their mother’s care and initially placed in separate foster care placements only seeing each other at supervised access visits. After an attempted reunification of Ellie and Xavier to Louise’s care was not successful they were placed together in foster care. Justin was removed from Louise’s care some years before Ellie and Xavier. He lives in a residential unit due to his sexualised behaviours.

Justin has had multiple foster care placements, including voluntary and respite placements. On access visits with his father Justin was repeatedly sexually abused, which resulted in extensive surgery. There are concerns that Justin may have sexually abused Ellie and that Ellie has sexually molested Xavier.

What Take Two did:
Justin, Ellie and Xavier were allocated to three clinicians from one of the Take Two teams, where the work was coordinated through regular meetings.

Justin
Justin commenced weekly psychotherapy sessions with Take Two, to assist him to develop an understanding of the damaging and dangerous consequences of his sexual offending behaviour, through engagement and confrontation. The clinician sought to help him cease the behaviours and change the related thinking patterns. The sessions also sought to enable Justin to process his traumatic history, so that it was less fragmented, persecutory, re-traumatising and overwhelming. A focus was to promote insight and develop a connection about how Justin’s past affects him today and to understand how to prevent repetition of past trauma. Furthermore the clinician helped Justin to develop trust and confidence in the wider system being able to protect and nurture him. There was also work on helping him to express his desires appropriately, thereby allowing him to have some sense of control over his world.

Justin’s clinician commenced individual sessions with Justin’s mother Louise, to support her in responding more confidently and consistently to Justin’s and the other children’s needs. Similarly the clinician sought to aid Louise in developing more regular and positive patterns of attendance at access, and in maintaining contact with the children. A care team was established and the clinician met regularly with residential carers and professionals to establish consistency in management and awareness of Justin’s history, including work with his school. Ongoing liaison with other services including disability services and police occurred. The clinician maintained a high level of communication with Child Protection so that all major issues had immediate discussion as to the best way to proceed and long-term planning for his needs.

Ellie
Initially the Take Two clinician visited Ellie and her carer at home, but when the carer reported that Ellie became unsettled and difficult to manage after sessions, appointments were changed to the Take Two office in order to reduce anxiety and confusion.

Therapy with Ellie involved a combination of approaches. Individual therapy sessions sought to assist Ellie to articulate her feelings and beliefs through unstructured play. The clinician advocated for more consistent access between Ellie and Xavier prior to their placement together in a foster home and for consistency in workers transporting Ellie to placement. In addition, the clinician conducted regular consultation with care team members to support them in understanding Ellie’s needs. In particular the clinician worked with the system to assist them in understanding the impact on Ellie of repeatedly missed accesses. For example, she spoke of Ellie’s experience of being left waiting at school when access had been cancelled without the school or carers being notified, as this served to reinforce Ellie’s fears of abandonment. The clinician also advocated for more timely and cooperative information provision and provided psycho-education regarding the importance of early intervention with traumatised children, thereby encouraging care team members to actively support therapy. Prior to system intervention, long delays in stability planning occurred, carers felt unsupported and recommendations were not followed up in a timely manner.

Xavier
Given his history of disrupted attachments, Xavier’s clinician sought to assist him to develop a more confident sense of self, to self-regulate and reach appropriate developmental levels in expression of emotion. Initially the clinician met Xavier and his carer in his placement, which over time became individual sessions in the home, and then eventually individual sessions at the Take Two office. The office-based sessions provided Xavier a place to explore difficult feelings associated with his experiences of emotional neglect, trauma and abandonment. The assessment of Xavier highlighted his language difficulties, hypervigilance and low tolerance of frustration. This suggested using a combination of approaches, including cognitive behavioural techniques in the context of unstructured play. This approach allowed Xavier to explore his sense of family and belonging in a neutral setting and experience a sense of control while learning to manage his frustration.

Take Two continued to support Xavier’s carer and case manager. On a few occasions the carer observed part of Xavier’s individual sessions through a one-way screen. This provided the opportunity for the carer to discuss Xavier’s therapy with another Take Two clinician and make links to her own experience of Xavier in the home. The parallel work with Xavier’s carer enhanced her understanding of Xavier’s inner world, and helped her to assist Xavier in his overall development and in building relationships. The partnership with the clinician assisted the carer in perceiving Xavier in a more balanced way, reduced her sense of isolation and improved the attachment and affection between them. The clinician provided consultation to Xavier’s care team.

Outcomes:
Justin
Individual therapy has resulted in Justin being able to recognise and regulate his emotional state. Justin explored his history of abuse and abandonment both physically and with limited language. The liaison with the school was successful as the
Xavier
Xavier has developed a stronger sense of family through access and regular contact with his siblings. He is now able to appropriately express feelings of frustration, disappointment, sadness, anger and delight. He is able to regulate his emotional responses with appropriate self-management strategies. Xavier's independence and confidence has improved to a more age appropriate level. He now asks for assistance when needed and has formed an appropriate attachment with his carer. Xavier's carer developed greater empathy for him and has expressed her desire to maintain contact with him on a long-term basis. The one-way screen sessions provided invaluable education, affirmation and reassurance to the carer. The care team demonstrates greater understanding at the 'slowness' of therapy, which is driven by Xavier's own pace, and his need to feel safe before he can establish trusting relationships. The care team has a greater recognition and understanding of how Xavier's inner world is expressed in his behaviours and relating style.

Overall the three clinicians found that the flexibility in approach with the family and engagement with the service system at all levels ensured the therapeutic intervention maintained momentum and continued. The sharing of theories and ideas amongst the team was vital to providing intervention responsive to the needs of each of the children, as well as responding to the interaction between the care system and the siblings. Staying with carers through their frustration and difficulties; and staying with children through their regression, despair, confusion and anger has yielded major positive outcomes.

The two sources of data for looking at outcomes for the 29 cases were the clinician's perspective as described in the staff journals and looking at available outcome measures. The staff journals also often reflected feedback clinicians had received from others such as parents, carers, Child Protection workers, schools and others. Nineteen cases had one or more outcome measures although only 13 of these were completed over more than one time period to provide a sense of change over time. A detailed description of the Social Network Map, TSCC and the SDQ is in Chapter 2 and the preliminary results are in Chapters 7-9. For the purposes of this chapter it has been useful to draw upon both the clinician's perspective and the outcome measures when available and compare notes.

Ryan and Jones (2005) in their review of the Take Two Practice Framework found that clinicians were cautious in claiming success in clinical work. However, many of these cases were chosen by the clinicians because they demonstrated particular outcomes. A frequent outcome listed by clinicians was strengthening the child's relationship with their family and/or carers, by primarily strengthening the carer's/parent's ability to respond more consistently and effectively to the child. Helping the parent or carer understand the child's behaviour and this being subsequently demonstrated through a change in the way they interact with the child was described in 13 cases. This overlapped with supporting the attachment relationship between the child and his or her parent or carer, so that the child grew in confidence that they would be safe and kept in mind. For example, three staff journals noted that the child's emotional state was more regulated by the parent's or carer's emotional state as a result of Take Two intervention.

Nineteen journals mentioned a reduction in the children's emotional and/or behavioural symptoms as the children began to develop a capacity to name their fears and anxieties and engage in therapy. For some children this led to a reduction of difficult behaviours, while for others it meant the beginning of a long journey in healing from the significant trauma they had experienced. Observable changes in difficult behaviours would take time to occur. However, in each of the cases a key outcome was the child being able to engage in an assessment and the therapeutic intervention which required a degree of trust. The success of the engagement can be linked to the skill and persistence of the clinician and the remarkable resilience of these children to be prepared to trust adults again.

Examples of symptoms that were noted as reducing were self-harming behaviours, violence to others, substance
abuse, absconding, school refusal and reduction in enuresis and encopresis. Other indicators of positive change included re-engaging with the school, such as a child who had been suspended for nearly two years beginning to attend regularly; increased impulse control; improved peer relationships; a willingness to talk about their thoughts and feelings; improved sleep patterns, cultural connectedness and stronger sense of family and self-identity. These changes are illustrated in the following quotes.

A worker who knew her a number of years ago remarked the she now has more of a sense of identity and self-worth, as well as a developing understanding of her role in the family and network. (Staff journal)

His behaviour has improved dramatically. He feels a little more supported and stable at home although has some contempt for his mother, he is respecting her position more. Mother is also taking charge and providing boundaries - and therefore some security for him. I think personally, he has a much clearer view of his life - he is not as confused about what is going on … There are better systems around him, especially at school, and the school have worked hard with him. (Staff journal)

Wendy has learnt the pleasure of play and can use others in her play. She is more spontaneous and as her anxiety has decreased she is confident in trying new things. Her ability to engage in play has increased dramatically. (Staff journal)

Greg’s ability to socialize and make friends has helped change the way he sees the world. He now feels safe to confide in trusted adults. (Staff journal)

Outcomes consistently noted by clinicians included changes in the response of the service system, more appropriate placements and school involvement. Development of care teams which work collaboratively to support the child is an important outcome for dealing with the complex world of the child. When the care team occurred it provided the children with a needed champion of their rights and needs, something which had often been missing. In this way the care team approach was both an intervention and an outcome. Changes in the family and carers were also frequently noted including parents being able to preference the child’s needs above their own and parents and carers providing greater structure and stability for the child.

When analysing the outcome measures, eight cases had at least one measure which indicated some level of improvement. In another three cases there were mixed results with one measure showing improvement and another showing a particular group of symptoms to have worsened. In the remaining two cases with available measures over two time periods, the outcome measures indicated that particular emotional or behavioural responses had worsened at time of review.

Sometimes a clinician’s assessment is that the child’s emotional and behavioural symptoms have reduced, yet an SDQ or TSCC will indicate that the child, carer, parent or teacher are just as worried, or sometimes more worried than they were previously. This highlights both the value and the limitation of any one or group of standardised measures.

As seen in Grant’s story, at the time of review the Take Two clinician believed that significant changes were occurring especially as he was beginning to start to talk about his and his sister’s experience of trauma. However, the outcome measures completed at the time indicated that he was showing increased symptoms in some areas, especially related to trauma symptoms, depression and anxiety. Although these two perspectives are not necessarily contradictory, they are certainly complex and highlight the need for Take Two to be working with the carers and teachers throughout this process as well as directly with the child.
Grant's Story

Grant's Family

Dot 50 years
Basil 54 years
Gail (dec)
Angus 62 years

Pat 28 years
Melissa 27 years
Tristan 34 years
Jade 26 years
Sally 39 years
Tony 43 years

Permanent Carers

Grant 7 years
Angela 3 years

Grant's presentation to Take Two:
Grant is a seven-year-old boy and has been living in foster care with his three-year-old sister, Angela, for the past two years. Grant was referred to Take Two with behavioural issues that have been reported for three years characterised by extreme physical aggression, stealing, lying, attacking other children and property destruction. In his placements he was described as lighting fires, shredding his carer's clothes, harming animals, destroying property, threatening to abscond, bedwetting, sexualised behaviours and urinating on his sister. Grant exhibited a range of symptoms of extreme and chronic anxiety and low self-esteem. He appears to take on responsibility for his parents' behaviour.

Grant presents with a range of adjustment disorder and post-traumatic stress symptoms along with somatic symptoms such as asthma and eczema. Grant was diagnosed with Attention Deficit Hyperactivity Disorder. However, his behaviours can also be understood as strategies to avoid intrusive traumatic memories and extreme anxiety, based on past experience of intense fear.

What happened to Grant?
Grant has suffered a history of abuse and neglect with notifications resulting from exposure to serious family violence, inappropriate discipline and physical abuse. It is believed that Grant's father suffers Schizophrenia, and his mother has periods of psychological instability and drug and alcohol abuse. Both parents have spent significant time incarcerated and the children have been exposed to their parents' criminal activity and drug use. The children have witnessed violence and abuse between their parents as well as other adults. As a result, Grant has had various placements, primarily in foster care, since the age of three. Grant has told his carers that he is used to his parents going to gaol and he does not believe violence or crime are unusual. The adults in Grant's life report that he has trouble distinguishing between reality and fantasy.

After a number of reunification attempts, Grant and Angela were placed on Custody to Secretary orders following the incarceration of both parents. Grant has expressed the wish to remain with his current carers until he can return home to his father. However, the current case plan is for Grant and Angela to be placed in permanent care with Sally and Tony. Grant's behaviour is reported to be more aggressive and anxious around access visits with his mother and court cases.

What Take Two did:
The Take Two clinician set out to assist Grant in developing empathic responses to others, to appropriately express his emotions, regulate his own behaviours, develop strategies to manage his anxiety, and talk about his fears in the context of a safe relationship. During the first few months of engagement with Take Two the clinician sought to establish a trusting relationship with Grant, initially at his school and then at a local office, meeting on a weekly basis. At first, Grant was extremely anxious and controlling of the discussion and activities in sessions. After six months of therapy he began to make more eye contact, smile, and take more direction from the clinician, slowly ceding control.

Initially Grant had been very reluctant to talk about his experiences and so play therapy was used in the sessions. This contributed to improving self-esteem by acknowledging his strengths and enabled appropriate social and interactional skills to be learned in a fun way, such as 'a good batsman knows when the game is over'. Through the sporting activities and use of these as metaphors Grant is learning how to regulate his own behaviour, operate within boundaries and set his own boundaries. Through the play therapy Grant's fears and confusion became evident.

The clinician had regular care team meetings held on a six-weekly basis with the Child Protection Case Manager, the school and his permanent carers. These meetings provided the opportunity to discuss issues regarding Grant's progress, and to
enhance understanding of Grant’s difficulties so that appropriate support and responses to his behaviour could be implemented. Intervention plans and goals were developed in these meetings which also provided the chance for discussion and regular feedback.

During Take Two’s intervention, Grant’s sister Angela made a disclosure of abuse, which led to a police investigation. As Grant had witnessed the police involvement without anything negative happening, he was able to open up and talk about his fears and thoughts in therapy. Grant is now progressing to the stage where his earlier life trauma can be processed in sessions. This is an unsettling time for Grant although now the therapeutic relationship has already been established it is hoped that this gives him a safe place for support.

Outcomes:
The outcome measures in relation to Grant were the SDQ completed by his carers and teachers and a Trauma Symptom Checklist for Young Children (TSCYC - Briere, 2005), which is a parent/carer report measure more recently implemented within Take Two. Both of these measures showed that Grant was in the clinical range in relation to various emotional and behavioural problems at the time of assessment and that these remained the same or had worsened at time of review. For example, according to the SDQs completed by the carer, Grant was showing similar concerns regarding conduct problems, hyperactivity and peer relationship difficulties at time of assessment as at review. However, the same carer completed the TSCYC around these times which showed that during assessment he scored in the clinical range in posttraumatic stress symptoms and dissociation, whereas at time of review he was scoring in the clinical range in posttraumatic stress symptoms, depression and anxiety.

Such findings provide important information to help the clinician consider what is happening for Grant at this time. Given these review measures occurred around the time of Grant’s sister making a disclosure and Grant beginning to use therapy more directly to talk about his feelings, one possibility is that this is temporarily creating more instability while he is trying to make sense of what has happened to him and his sister. This hypothesis is consistent with the TSCYC results relating to symptoms associated with depressive thoughts, anxiety and more direct trauma symptoms.

According to the clinician, Grant’s presentation at the beginning of therapy had already improved as a result of seven months of stable foster care, where the carer had provided him with consistency and firm boundaries. The clinician wrote that Grant has since been developing a stronger sense of self-esteem especially through his sport and he is progressing at school. He has been forming more positive relationships and is responsive to reward and approval strategies. Grant thrives on one-to-one attention and is increasingly showing the capacity to adapt and learn appropriate social behaviour and skills through rewards and firm boundaries.

Grant has continued to improve his social skills and self-esteem considerably throughout the last nine months and he looks forward to therapy. Grant has noticeably improved in non-verbal communication through increased eye contact, expressive responses, turn-taking in games, and demonstrates more awareness of the needs of others. Grant can now sit and play games with patience and can follow rules. Grant can now recognise his inappropriate behaviour and apologise. (Staff journal)
In other cases there was almost unanimity of view that at the time of review or closure the child had made significant improvements in most areas. For example, in one case the Social Network Map completed by a ten-year-old girl showed that she considered more people in her life to be close and emotionally supportive. In terms of the TSCC, she had reported as being in the clinical range in anxiety, depression and anger at review, but at the time of closure was presenting in the normal range for all but anger. The SDQ showed that according to her mother her overall difficulties had reduced from the clinical to the borderline range. According to both her mother and her teacher, she had gone from the clinical to the normal range in her emotional concerns. Her mother had also reported she was no longer in the clinical range regarding conduct problems. In that part of the SDQ that enables the respondent to say if they believe change occurred and if the service helped, both mother and daughter agreed that she was doing much better and that Take Two helped a great deal. The two teachers who completed the SDQ varied between whether the child was ‘a bit’ or ‘much’ better and whether Take Two helped ‘a medium amount’ or ‘a great deal’.

In another case of a 14-year-old boy with major violence and self-harming behaviours, his Social Network Map reflected a mixed picture as he had recently changed schools so had reduced the number of ‘very close’ friends. However the SDQs conducted at assessment, review and closure showed that from the carer’s perspective he was no longer in the clinical range regarding overall difficulties, emotional symptoms and peer problems. By the time of closure, according to the carer, he had moved into the normal range in most areas, except was borderline regarding emotional symptoms and conduct problems. The child and teacher’s SDQs had shown no concerns in any of the scales across the different time periods.

Shane’s story provides another picture in relation to outcome measures. Shane completed Social Network Maps, TSCCs and SDQs and his carers and teachers completed SDQs. Most of these measures showed positive change in relation to Shane’s emotional and behavioural symptoms.

Shane's Story

Shane’s presentation to Take Two:
Shane is a 13-year-old boy, who when referred to Take Two was residing in foster care. He presented to Take Two with a long history of difficult behaviours, including verbal and physical aggression, disruptive and oppositional/defiant behaviours. These behaviours were reported as having increased as Shane became older and had become increasingly unmanageable. He had been suspended from school indefinitely and was considered to have a high probability of future placement breakdown. Shane had been diagnosed with Attention Deficit Hyperactivity Disorder and was taking medication prescribed by a paediatrician.

Due to his many placement changes, Shane has attended several schools in his nine years of education. Despite multiple suspensions and expulsions, he attended school regularly until his indefinite suspension from school when he was 11 years old. Shane has above average academic abilities, although due to his distraction levels he tends to fall behind on his work.

What happened to Shane?
Shane had experienced repeated rejection and abandonment by his parents and as a result had a minimal sense of belonging and permanence. This was further exacerbated by multiple placements and subsequent moves in out-of-home care. Shane is the only child of Liz and Erik, who had children with previous partners. Their relationship ended when Liz was pregnant with Shane. Erik denies paternity of Shane. Shane has three much
older half-siblings and four nieces and nephews, but has minimal contact with them.

During his infancy Shane lived with his mother and two siblings. Little is known about Shane’s early development but reports from three years of age indicated that Liz was not providing suitable supervision and failed to meet his basic physical and emotional needs. Shane’s many placements were terminated due to his difficult behaviour.

Liz cared for Shane intermittently until he was seven years old, although she first reported difficulties in caring for him when he was three. Liz placed Shane in respite care and at the age of six he went into his first full-time foster care placement when she said she could no longer care for him. Once placed in foster care Liz’s contact with Shane was sporadic, and she went for extended periods without contacting him at all. Shane perceives this as multiple rejections by his mother. When he was 11 years old, Liz told Child Protection that she no longer wanted contact with Shane due to personal issues. His contact with his maternal siblings also ceased at this time, although he has more recently resumed contact after many years with some of his paternal siblings.

During Take Two’s involvement Liz resumed contact with Shane. Following Child Protection’s assessment the case plan was changed to reunification and Shane eventually returned to her full-time care. Take Two was involved both prior to and following reunification.

**What Take Two did:**

Given Shane’s long history of multiple placements, rejection by his family, suspensions and expulsions from school, the clinician’s primary intervention was to try to engage Shane and gain his trust, feeling that Shane was a child who required a slow and steady approach. The clinician saw Shane every week, usually on the same day, at the same time and the same place, for almost two years, to create some predictability. The process of engagement was slow and Shane was resistant to attending sessions. The clinician made them as fun and non-confrontational as possible, using board games, and allowing Shane to take the lead in the conversation. As Shane began to trust the clinician, he began to engage at a deeper level. When Shane moved back with his mother, he continued to attend weekly sessions, but his mother attended half of each session with him. This way Shane could verbalise his hurt to her about the rejection he felt and it allowed his mother to acknowledge this and her own hurt.

Regular care team meetings occurred throughout Take Two’s involvement and were attended by Child Protection, the case manager from the Community Service Organisation, his mother, professionals from numerous family support services, a psychiatrist, education support services, teachers and occasionally Shane’s paediatrician. All decisions regarding case management were discussed in the care team meetings. This ensured that the complexity of the case was given consideration and the communication within the system worked effectively.

Without a stable and functioning care team, the clinician considered that the progress made in Shane’s case would have been greatly reduced.

One of the goals was for Shane to be enrolled in school and attending full-time, so the clinician met with the school regularly to develop strategies to manage Shane’s difficult behaviours and provide consultation. The focus was on assisting Shane to develop appropriate peer skills and see a reduction in his difficult behaviours. The clinician also met regularly with Shane’s foster carers, to support the placement and assist in stabilising placement and preventing further moves until he returned home.

**Outcomes:**

Shane and his network of family, carers and teachers completed a range of outcome measures over three time periods, namely initial assessment, review and closure. Shane completed a Social Network Map at time of initial assessment and then at closure. Although there were slightly fewer people in the second map, family members, especially his mother, had moved from the outer rim of his life to being described as ‘very close’. Shane also changed from thinking of his mother as ‘hardly ever’ to ‘almost always’ emotionally supportive. Most of the professionals listed including the Take Two clinician had moved from ‘not very close’ to ‘sort of close’.

In terms of the SDQ, these were completed by Shane, his carers and teachers. His mother completed one at closure instead of the carers as he had returned to her care. In comparing the SDQs completed by the carers at the initial assessment and review period, they recorded that Shane was no longer in the clinical range in terms of the total difficulties score and for hyperactivity.

Over the three assessment periods, Shane recorded a reduction in his overall difficulties score, particularly in relation to the hyperactivity scale. Apart from an improvement in hyperactivity, teachers (who were different at each time of gathering outcome measures) were the only respondents who noted ongoing clinical concerns for Shane at time of closure, although an improvement in all areas had been noted by those teachers involved at the earlier time of review.

The first TSCC was invalid due to under-reporting and the second and third (closure) measures both showed Shane in the normal range regarding anxiety, anger, posttraumatic stress symptoms and dissociation.

When Take Two ceased involvement with Shane he had been attending school full-time for 15 months, and with minimal disruption. Although he was still displaying some difficult behaviour, the school was more able to manage these. Shane’s carers reported that over the time he had been with them his aggressive outbursts became less frequent, although just as severe. When Shane reunited with his mother after six years in care, he was having regular contact with his family, including his paternal family. Shane has developed a few significant friendships despite continuing difficulties in relating to his peers and has developed more insight into himself and some capacity to reflect on his experiences. This in turn led to a reduction in difficult behaviours.

**Over time Shane began to confide more in his mother and she gained skills in listening to him and meeting his needs.**

(Staff journal)

As seen via the quantitative and qualitative outcome measures and supported through the clinician’s broader assessment, Shane continues to be emotionally vulnerable as a result of his past experiences but has shown considerable improvement in his personal functioning and relationship with his mother. Take Two’s closure was based on the assessment that he is now able to continue this process of recovery through the support of a local family service.
6.9 Summary

The severity of abuse experienced by the children over a long time period has led to a high degree of trauma and disrupted attachment. By the time they are referred to Take Two they are also engaged in a complex service system. The cases analysed and described in this chapter highlight the importance of the active intervention of Take Two with the child, family/carers and the service system in collaboration with other services. The cases demonstrate the need to have a flexible response as each child’s situation whilst complex is also unique.

As seen in these vignettes and more detailed case studies, outcome measures in conjunction with assessment and other forms of feedback can provide a powerful representation of what is happening for the child, but interpretation can be complex on a case by case basis.

Johnny hated formal sessions, and especially didn’t like doing the outcomes measures testing. However, they proved a good tool for engagement. Particularly the grid for the social network map which became the common task we had to get done together. He also didn’t like the TSCC, in particular the ‘yucky sex’ questions. However, I think the anxiety over asking them was mine, and he dealt with them ok. (Staff journal)
Chapter 7: Outcomes - Social networks - children's view of who is in their life

7.1 Overview

Social Network Maps are utilised in the Take Two outcomes framework to provide an indication of changes to the children's social network during their involvement with Take Two. They are also used to provide a baseline picture of the children's perception of who is in their life. In this evaluation report the Social Network Maps completed by clients of Take Two in 2004 and 2005 are used to describe qualitative examples of clinical outcomes. Emerging themes are also examined and compared with relevant literature.

As stated in Chapter 2, research has found that perception of support was more highly correlated with wellbeing than received support (Robinson & Garber, 1995). The Social Network Map places more emphasis on the child's perception of relationships than describing who is actually involved in the child's life. Take Two has used this methodology innovatively to apply it to this client group and in the process of analysis.

7.2 Description of the Social Network Map within Take Two

At the time of this evaluation, 54 Social Network Maps were fully or partially completed by 42 children who were clients of Take Two in 2004 and 2005. Ten children completed one or two repeat measures of Social Network Maps over different time periods. Although this number of repeat measures is not sufficient to generalise across the client group, they have been useful in analysing how Social Network Maps can be used in the future for measuring change over time. Table 27 shows the number of Social Network Maps that were undertaken at various phases of Take Two involvement.

Table 27
Number of Social Network Maps Completed during Take Two Involvement (N = 53)

<table>
<thead>
<tr>
<th>Assessment phase</th>
<th>Review phase(s)</th>
<th>Closure phase</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Social Network Map</td>
<td>23</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>2nd Social Network Map</td>
<td>7</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>3rd Social Network Map</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Note. 1 missing - insufficient information was available to determine phase when Social Network Map was completed.

As described in Chapter 2, the Social Network Map consists of two components: (1) a circle where the child lists all the people in their life; and (2) a grid where the child is asked to list the top 15 people and provide more detail regarding these relationships.

Forty-three (80%) of the 54 Social Network Maps were sufficiently complete to include in the analysis. Incomplete measures either had no grid and only a circle or too much missing data in the grid to be used in the broader analysis. Reasons noted by clinicians for incomplete grids included the child's young age, level of development or lack of interest. Even when only maps were completed this was often able to provide interesting insight into the child's perception of his or her world. For example, one child who completed a circle but not a grid wrote . . .

"Dad's bonkers - if he finds me I am going to hang on tight so he can't take me."

Twenty-three completed grids were accompanied by a circle. Another nine circles were completed without a grid. Overall there were 32 circles completed as well or instead of a grid.

Over four fifths (85%) of the Social Network Maps were completed by clients of rural teams. The average age of the children attempting Social Network Maps was 10.7 years with a range from two children who were six years of age to one 16-year-old. Consistent with the Take Two population (not including Secure Welfare), 65 percent of those completing the Social Network Maps were males. Seven (13%) Social Network Maps were completed by Aboriginal children. This is slightly less than the 15 percent of Aboriginal clients involved in the overall Take Two program over the two years. The majority of children completing Social Network Maps were in some form of out-of-home care (83%), which was a slightly higher proportion to those in the broader Take Two population (78%).

Although some preliminary information was analysed from 32 circles, most of the analysis has been obtained from the more detailed grids. There were 31 complete baseline grids for 31 children and 12 complete repeat grids for ten children. Due to the small numbers, tests of significance were not considered appropriate. However, a qualitative perspective looking at common themes and patterns across these grids was undertaken. A single case design analysis was then undertaken in relation to the ten children who completed more than one Social Network Map over different time periods. A template was created to assist in the qualitative analysis that graphically highlighted the children's perceptions of their networks. These were presented in diagrammatic form which assisted the analysis, as seen in Figure 23. In this example, Andrew who is in a residential placement perceives only one person as very close to him and that is a friend.
7.3 Who is in the child’s life?

The circles and grids ask different questions regarding who is in the child’s life. The circle asks an open-ended question about the number of people in their lives, whereas the grid asks about the most important or ‘top’ 15 people.

The average number of people listed in the 32 circles was 28 (SD = 13.7) ranging from five to 61 people. Children were likely to list more people who were family, friends and household than neighbours or those they knew through organisations, such as sporting clubs or churches. This finding is consistent with the study undertaken by Tracy (1990) of at-risk families.

A number of authors (Cochran & Brassard, 1979; Saulnier & Rowland, 1985; Tracy, 1990; and Shankar & Collyer, 2002) contend that the size of the social network is not a useful indicator of its strength. Saulnier and Rowland (1985) in a study of at-risk families found the frequency of interactions with the networks was strongly associated with therapists’ concerns and with whether the children were eventually removed from the family. Tracy (1990) found that influential factors on outcomes were: the composition of the social network; the amount of conflict; and the level of reciprocity. However, although this was the case for adults, issues such as reciprocity require developmental milestones to be achieved before being sufficiently understood by children (Cochran & Brassard, 1979). Robinson and Garber (1995) noted that middle childhood is when an understanding of reciprocity is usually developed.

As seen by comparing Figures 24 and 25, when children had to select those most important in their life, those in their household and family became even more predominant (increasing from 45% to 57%).
7.4 Frequency of contact and longevity of relationships

The 31 children listed a mean of 15 people with a range of 10 to 18 people per grid. The majority of children listed at least one person with whom they were in daily contact. However, one child listed no one with whom he had more than weekly contact and another child listed only two daily contacts, one of whom was her cat. Those who were listed as having daily contact were usually living with the child or school friends and teachers. In terms of frequency, children were in contact with people in their network:

- 37% daily or several times a week ($M = 5.4$ people per child, $SD = 2.9$);
- 33% once a week ($M = 4.8$ people per child, $SD = 2.8$);
- 13% monthly ($M = 1.8$ people per child, $SD = 2.1$); and
- 17% only a few times a year or less ($M = 2.4$ people per child, $SD = 2.4$).

Although needing to be careful in making comparisons with studies regarding adults, this frequency of contact is not dissimilar to that reported in Tracy’s 1990 study of at-risk families.

Length of relationships is seen as a sign of stability, although particular caution must be taken when considering this for children. The length of time the children knew people in their network was as follows:

- 38% for more than five years ($M = 5.5$ people per child, $SD = 3.3$);
- 36% between one to five years ($M = 5.2$ people per child, $SD = 3.8$); and
- 26% less than one year ($M = 3.8$ people per child, $SD = 3.2$).

Although this is not a large variation from Tracy’s 1990 study regarding the percentage of those known for less than a year, it is less for those known more than five years (53% in Tracy’s study compared to 38% in this study).

Three factors need to be considered when analysing length of relationships for children. Firstly, the younger the child, the more it is expected that their social networks will be smaller in size and more directed by their parents or carers (Cochran & Brassard, 1979; Robinson & Garber, 1995). Secondly, children’s age is often associated with transition points, such as change of school. Changing schools is likely to be a key determinant of who is in the child’s network in terms of school and friendships. The third factor and specific to children in the protection and care system is the number of times children experience changes in placement and school. The mean number of previous placements for these 31 children was six ($SD = 4.9$), with a range from no changes to 18 placements prior to referral to Take Two.

7.5 Child’s household

At the time of completing the baseline grids the 31 children’s living situations consisted of:
• 8 (29%) lived with one or both parents;
• 5 (18%) lived with kith or kin;
• 15 (53%) lived in some other form of out-of-home care, 13 of whom were in home-based care; and
• 3 missing data.

Due to the high proportion of children living away from their family, it is important to take this into consideration when analysing both household and family data. Unlike studies such as Tracy’s (1990), where it was assumed that family members outside the household were mostly extended family, for many of the children in Take Two family members outside the household are parents and siblings.

The average number of people listed in the child’s household was three people with a range from zero to eight people. One child did not mention anyone from his household; another four did not mention anyone in a caregiver role. These four specified such relationships as siblings, other children and pets. Overall, there were 103 people mentioned in households, not including the child.

Figure 26 shows the level of closeness by type of carer as described by the 26 children who mentioned one or more carers. Of the 103 listed in the household, 62 percent were described as ‘very close’. This percentage was greater (74%) when only the 42 carers were considered. Seventeen of the 26 children who listed carers (65%) described one or more of those who cared for them as ‘very close’, ‘almost always’ emotionally supportive and ‘almost always’ providing concrete support. This response was equally distributed regarding parents, kinship carers and foster parents. The kinship carers were primarily grandparents. Two of the four children in residential care expressed a similar opinion regarding the high level of support they received from their residential carers.

Although most carers (n = 20; 77%) who were described as ‘very close’ were also described as ‘almost always’ providing emotional and practical support, there were examples where the level of closeness was not aligned with perception of helpfulness. For example, one child described her foster parents as ‘very close’, but ‘hardly ever’ emotionally or practically supportive. Three children described their carers as ‘sort of close’ but ‘almost always’ emotionally and practically supportive. When other household members are included in the analysis a different pattern emerges. Of the household members who were described as ‘very close’, less than two fifths (39%) were described as ‘almost always’ emotionally and practically supportive; whereas 28 percent were described as ‘hardly ever’ emotionally or practically supportive. Most of this latter group consisted of siblings and other children.

Four children included pets under ‘household’. One child distinguished between two pets, noting that one provided some emotional support and the other did not yet as he was too young. In addition to what this reflects about the child’s perception of her world, it indicates her understanding of the questions in the map. Apart from the pet that the child considered was too young, the other animals listed by four different children were all described as providing emotional but not practical support. This again illustrates the children’s understanding of the questions and the role of animals in their lives.

Figure 27 shows that over half the children (n = 14; 56%) knew their carers for more than five years, especially when they were living with their immediate or extended family. One child in residential care and one child in foster care knew their carers for less than a year. The residential carer who had known the child for less than a year was described by the Take Two clinician as the most stable person in the child’s life. Conversely another child in residential care knew his carers for over five years.

5 One child included himself in the Social Network Map under ‘household’, but is not included in this total.

6 Unless otherwise specified, percentages are based on the number of people whose role could be identified not the total number of people mentioned in grids.
7.6 Child’s family

In the baseline Social Network Maps, all except one child described at least one person as a family member, under either family or household categories. Analysis showed that across ‘family’ and ‘household’ classifications, where information was available:

- 28 (90%) children listed one or more siblings;
- 21 (68%) children listed their mother;
- 16 (52%) children listed one or more grandparents;
- 11 (36%) children listed their father;
- 10 (32%) children listed one or more undefined family members;
- 6 (19%) children listed a step-parent (mostly step-fathers);
- 6 (19%) children listed one or more aunts or uncles;
- 5 (16%) children listed one or more cousins or nephews;

Seven children did not list either parent, all except one of whom had both parents who were alive. This is in contrast with three children who listed a parent who was deceased, each of whom described the parent as ‘very close’. Ten children (32%) made no mention of their mother and sixteen (52%) made no mention of a father or father figure.

Overall, fathers were noticeable by their absence. This is consistent with findings from the previous evaluation report (Frederico, Jackson, & Black, 2005) that found 48 percent of the children had no contact with their father. The child’s situation vis-à-vis being in out-of-home care appears to influence how they define their social network. As one clinician stated:

Even when a child loves their parents, and speaks about them readily, if they are not around then they don’t get mentioned as part of the social network. (Staff journal)

The most frequently noted family members were siblings (n = 67; 35% of those listed). Siblings were defined by the children themselves and usually referred to both full and half-siblings. The mean number of siblings mentioned was 2.2 per child, although according to Child Protection records, the mean number of siblings for this cohort of children was actually 3.6. In other words, it is likely that although siblings were a large proportion of family listed in the networks, there remained others who were not listed. According to the Child Protection records, the three children who did not list a sibling in their Social Network Map had at least three siblings, though were not living with them. Fifteen children appeared to have more siblings according to Child Protection and Take Two records than they listed in their networks.

Figure 29 shows that of the 28 children who listed one or more siblings in their network, 12 (43%) were not living with a sibling and another nine (32%) were living with only some of their siblings. One child listed all her other siblings, except for the one she was living with.
Figure 28. Social Network Map - Cameron 11 years of age

Inner circle - very close
Middle circle - sort of close
Outer circle - not very close
Direction of help

Inner circle - very close
Almost always emotionally supportive
Almost always provides concrete support

Middle circle - sort of close
Sometimes emotionally supportive
Sometimes provides concrete support

Outer circle - not very close
Hardly ever emotionally supportive
Hardly ever provides concrete support
The importance of siblings for many of these children has been emphasised in the Social Network Maps as well as in the literature. Researchers such as Ward (1984), Ainsworth and Maluccio (2002) and O’Neill (2002) have written regarding the complexity yet importance of placing siblings together where possible. They also argued that regardless of whether or not siblings were placed together it was important to ensure their relationships are acknowledged and supported. They emphasised the importance of understanding children’s attachment to siblings, as well as to parents.

It must be reemphasized that sibling ties can be more important to children than ties to parents. From the beginning of placement planning, the maintenance of these relationships must be of concern. (Ward, 1984, p. 330)

Rishel and her colleagues’ (2005) study highlighted the importance of grandparents in the lives of children. Just over 50 percent of the children included one or more grandparents in their Social Network Maps. Although smaller in number, it was also notable that a number of the grids included aunts, uncles and cousins.

The frequency of contact with different types of family members varied. For example, Figure 30 shows that 15 children saw at least one sibling daily or lived with them, whereas 11 children saw one or more siblings only a few times a year. Five children saw their mother daily or lived with her, compared to six children who saw their mother a few times a year.
This emphasis on family highlights that even though many of these children were in out-of-home care, family relationships remained important to them. Only one child lived with both parents though his parents separated soon after he completed the Social Network Map.

Figure 31 illustrates a child’s view of his connectedness with his family. It shows that the majority of family and friends provide emotional support to Matthew and he provides support to them. Matthew’s father, whom he only sees a few times a year, ‘hardly ever’ provides emotional support and yet he was listed in the inner ‘very close’ circle.

Figure 31. Social Network Map - Matthew 12 years of age

In terms of the proportion of family relationships described as ‘very close’:

- 23 (82%) of the 28 children who listed one or more siblings described at least one as ‘very close’;
- 13 (81%) of the 16 who listed one or more grandparents described at least one as ‘very close’;
- 11 (73%) of the 15 children who listed their fathers or step-fathers described at least one as ‘very close’;
- 15 (71%) of the 21 children who listed their mothers described them as ‘very close’;
- 4 (67%) of the 6 who listed one or more aunts and uncles described at least one as ‘very close’; and
- 3 (60%) of the 5 children who listed one or more cousins or nephews described at least one as ‘very close’.

Analysis of the Social Network Maps showed that, although children usually perceived family members as ‘very close’, this was not always the case. Perception of closeness was often but not always associated with those with whom the child lived.

7.7 Child’s school

Gilligan (2000) emphasises the importance of school for enhancing resilience in children, both in terms of teachers and peer relationships. He notes that schools can signify membership and belonging to a community, achievement, social relationships and learning. School life may be the only normalising experience for many of these children, especially those in out-of-home care.

In relation to young people experiencing adversity, there is evidence about the protective value of positive educational experience (Gilligan, 1998), and particularly in relation to young people growing up in care and their subsequent progress (Jackson and Martin, 1998). (Gilligan, 2000, p. 42)

Twenty-two children (71%) made some mention of people associated with their school. In terms of the total number of people listed in the grids, 62 (14%) were from school (M = 1.5; range = 0 to 9). Children varied as to whether they included teachers and/or school friends in this category. Fourteen grids specified teachers and nine specified school friends. It is probable, however, that a number of school friends were listed in the category of ‘friends’, rather than
'school' and so this is likely to be an under-estimate of the number of school friends. Those listed as school friends are analysed in the following section regarding friendships.

Of the children who specified teachers, eight described the teachers as 'not very close', although two of these children described other teachers as closer. Three children described some or all of their teachers as 'very close'. Two children who described five teachers as 'not very close' described the same teachers as 'almost always' emotionally and practically supportive. This supports the conclusion that some children were able to make the distinction between level of closeness and type of support offered, as was also found in the household and family categories.

Figure 32 illustrates the role of the school in the social network of a 12-year-old girl, Jennifer. She elected not to include her family in this her second Social Network Map. Her parents had been listed in the baseline Social Network Map.

Figure 32. Social Network Map - Jennifer 12 years of age

Fourteen children responded to the question regarding whether or not 23 teachers provided information and advice. The response was evenly spread across the three possible responses. Five children (29%) listed one or more teachers as 'almost always' providing information and advice. Six children (35%) listed one or more teachers as 'sometimes' providing such support and six (35%) listed teachers as 'hardly ever' providing such support.

A conclusion drawn from this analysis is that many of the children were able to distinguish between teachers in terms of levels of closeness and types of supports.

7.8 Child’s friendships

Generally, most of the children and young people struggle to establish friendships. It seems that trauma symptoms (especially to flashbacks and emotional dysregulation) sabotage friendship very effectively . . . it appears other kids often see this group as angry, unpredictable, disloyal, dishonest, aggressive and 'bad’. (Staff journal)

As one would expect, many of the children/young people we work with struggle significantly in forming and maintaining informal relationships with peers. (Staff journal)

As mentioned earlier, friends were listed in both the 'friends' and 'school' category. One child also listed friends in her household, while two others described one or two professionals as friends. Parker, Rubin, Price and DeRosier (1997) note that the term 'friends' can be used loosely by both children and researchers. For example, in one of the repeat measures, an 11-year-old boy described another boy initially as a friend, but upon clarification with the clinician he described this boy as an acquaintance. As seen in the following series of figures and commentary, a proportion of the friends listed in these Social Network Maps were described by the children as neither close nor offering support.

Overall 77 friends were listed by 23 children with a mean of 2.5 friends per child (range = 0 to 7). Figure 33 shows that six children (21%) listed no friends in their network, three children (10%) listed one friend, seven (24%) listed two friends, six listed three or four friends (21%) and seven (24%) listed five or more friends.
Most of the children (90%) completing the Social Network Maps were in middle childhood (spanning 6 to 13 years). This is seen as a pivotal time for developing friendships and learning about peer relationships. According to Parker and colleagues (1997), middle childhood is the period of time with usually the greatest number of friends, though the intensity of some of these friendships typically strengthens in adolescence. Middle childhood is described as a period characterised by a great deal of change and growth in interpersonal skills and as such in the quality of peer relationships (Parker, et al., 1997; Jackson & Warren, 2000). Although there is no clear pattern of how children will behave during this developmental period in relation to levels of cooperativeness with peers, it is a period of increasing complexity and flexibility.

As they move into middle childhood, children's discussion of friendship and friendship issues begins to indicate a maturing appreciation that feelings and intentions, not just manifest actions, keep friends together or drive them apart. Children also begin to appreciate that others' thoughts and feelings concerning social events may differ from their own…By the close of middle childhood, however, most children understand that friendship is an affective bond with continuity over time, space, and events. (Parker, et al., 1997, p. 102)

A key finding reported by Parker and colleagues (1997) is that positive friendships are a resilience factor following an adverse event/s if the child is not separated from the friend as a result. In other words, if children have to move placement or school and thereby also lose or reduce contact with positive friendship networks, not only will this be an additional stressor, but it can directly impact on their ability to cope with other stressors.

Of the 23 children who listed at least one friend in their Social Network Map, 12 (52%) described at least one friend as ‘very close’; 15 children (65%) described at least one friend as ‘sort of close’, and eight children (35%) described at least one friend as ‘not very close’.

Eleven (48%) children described their friends as ‘almost always’ providing emotional support and another 27 percent described their friends as ‘sometimes’ providing emotional support. Fifteen children (65%) described at least one friend as ‘hardly ever’ providing emotional support. In relation to practical support, only six (26%) described one or more friends as ‘almost always’ practically supportive and another nine (39%) described friends as ‘sometimes’ practically supportive. Fourteen (61%) described at least one friend as ‘hardly ever’ providing practical support. Although almost all of the friends were close to the children’s own age, and some grids did not include the friend’s age, at least four children had adult friends, including people in their sixties. One of these was a parent of a friend and another was a friend through a football club. All except one of these children had other friends their own age.

Thirteen children (57%) distinguished between their friends in terms of the type and frequency of support they provided. Figure 34 shows that nearly two thirds (65%) of the children had at least one friend they described as ‘hardly ever’ providing emotional support and a fifth described one or more friends as ‘hardly ever’ providing practical support. Over half the children (n = 13; 57%) described at least one friend as neither providing emotional nor practical support. Half the children (52%) described at least one friend who ‘almost always’ provided emotional support and a quarter (26%) described at least one friend who ‘almost always’ provided practical support. However, only four children (17%) described one or more friends as ‘almost always’ providing both types of support. As seen in Figure 34, in terms of the overall number of friends mentioned, the most frequent finding was that they ‘hardly ever’ provided practical support (51%), followed by ‘hardly ever’ providing emotional support (43%). In terms of the number of children who described their friendships, 65 percent listed at least one friend as ‘hardly ever’ providing emotional support.
Figure 34. Percentage of children’s descriptions of the types and level of support they received from friends (N = 23 children; 77 friends)

<table>
<thead>
<tr>
<th>Levels of emotional and practical support</th>
<th>% of children</th>
<th>% of friends</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost always emotionally supportive</td>
<td>52%</td>
<td>51%</td>
</tr>
<tr>
<td>Sometimes emotionally supportive</td>
<td>26%</td>
<td>39%</td>
</tr>
<tr>
<td>Hardly ever emotionally supportive</td>
<td>32%</td>
<td>19%</td>
</tr>
<tr>
<td>Almost always practically supportive</td>
<td>52%</td>
<td>39%</td>
</tr>
<tr>
<td>Sometimes practically supportive</td>
<td>43%</td>
<td>12%</td>
</tr>
<tr>
<td>Hardly ever practically supportive</td>
<td>65%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Percentage of children or friends
The perception of level of support had little bearing on whether the child described the friend as 'very close'. For example, of the 29 friends who were described as 'very close', 13 (45%) were described as 'hardly ever' providing practical support. Five of these 'very close' friends were also described as 'hardly ever' providing emotional support.

Providing information or advice was not a common aspect of most friendships. Half of the children's friends were described as 'hardly ever' providing information or advice (51%); compared to 33 percent who 'sometimes' provided information or advice; and 18 percent who 'almost always' provided information or advice.

Given the mean age for children completing the baseline Social Network Maps was 11 years of age and the mode was 12 years of age, school transition or the anticipation of transition are important themes to consider. Pratt and George (2005) highlight the significance of friendships for both boys and girls who are transitioning from Primary to Secondary school. One of the themes arising from their qualitative study was the children's anxiety and stress regarding the anticipated transition to Secondary school.

Choices of suitable allies as friends and being accepted as part of a group are critical for survival and for a reduction in feelings of vulnerability. (Pratt & George, 2005, p. 24)

In this evaluation, 12 children (52%) knew at least one of their friends for less than a year. Seven children (30%) only listed friends they knew less than a year. Two of these children were aged six and seven so it is likely that beginning school contributed to the recency of their friendships. The other children were aged between ten and 16, though it is still probable that changes in schools contributed to the absence of longer-term friends for some of these older children. In contrast five children (22%) had friends they had known for longer than five years. These five children were between ten and 12 years of age. Although it is not surprising that the younger age groups did not have longstanding friendships, it is of concern that six children aged 12 to 16 did not know any friends beyond the last five years, three of whom did not have friends beyond the last year.

In Figure 36, Simon’s Social Network Map depicts him as very much alone in his world with only one person - his kinship carer - 'almost always' providing emotional support which he reciprocates. The Social Network Map suggests that Simon has impoverished social support with Simon providing support to a number of family members which is not reciprocated in his eyes.
7.9 Professionals and workers from the child’s point of view

For some of the young people I work with, I am the most consistent person in their life. I think this is rather sad and reflects the state of their life. Another example, over the holidays I asked one young boy (10) who he missed. His response was, “my school teacher” and then after thinking added his mother and father. He hasn’t seen them for some months. (Staff journal)

Workers who were carers and teachers are discussed in earlier sections. For many of these children an eco-map would probably list numerous professionals in their lives, but the perception of the children provides a different and probably healthier perspective. Eight (26%) children made no mention of professionals in their Social Network Maps. However, five children mentioned four or more professionals, including two whom they described as both workers and friends.

Twenty-three children (74%) listed one or more professionals on their Social Network Map, 12 of whom listed two or three professionals. Professions included Take Two clinicians (the only ones usually present when the child completed the Social Network Map); Child Protection workers; placement workers, such as foster care workers; family support workers; and doctors. It is not possible to make comparisons across professions as a large proportion (n = 24; 52%) were not specified.

In terms of closeness, most professionals were described as ‘sort of close’ (47%), followed by ‘not very close’ (31%). The most frequently listed professional was the Take Two clinician, mentioned by 17 children. In terms of level of closeness, most Take Two clinicians were described as ‘sort of close’ (52%), with the remainder equally divided between ‘very close’ (24%) and ‘not very close’ (24%). Take Two clinicians were more likely to be described as providing emotional support rather than practical support.

Six children listed Child Protection workers of whom one was described as ‘very close’; four as ‘sort of close’; and one as ‘not very close’. Four Child Protection workers were described as ‘almost always’ emotionally supportive, while the other two were described as ‘hardly ever’ providing emotional support.

7.10 Neighbours and neighbourhoods from the child’s point of view

Six children (20%) listed someone they knew from a club or organisation. These were typically churches or sporting clubs. In addition, four children listed one or two neighbours.

The importance of recreational and community participation for children at risk has been highlighted by Gilligan (1999, 2000) and should not be underestimated for these children.

One favourable experience may be a turning point in a child’s or young person’s trajectory or development. (Gilligan, 2000, p. 39)
A Take Two clinician highlighted in their journal (2005) the challenge of extending the young person’s network. Trying to find alternative social connections for them is extremely difficult, there is a lack of educational alternatives, and the care situation does not meet their needs. Clients at home or in other placement options seem to have better social networks. (Staff journal)

7.11 An overview of levels of closeness and different types of support

In terms of the children’s descriptions of closeness of all those listed in their networks, 47 percent were described as ‘very close’, 34 percent as ‘sort of close’ and 19 percent as ‘not very close’.

On average more people (57%) were perceived by children as ‘hardly ever’ providing concrete or practical support than as providing it. On average people were described by children in relatively equal terms across the range from ‘almost always’ (49%) to ‘hardly ever’ (47%) providing emotional support.

In terms of contact with those in their network, on average, children were in contact with 53 percent of those listed on a daily basis and 46 percent on a weekly basis. Those listed on a daily basis were most commonly members of their household or those they knew through school.

The children knew just over half of the people (54%) in their lives for five years or more, most of whom were family members.

7.12 Social Networks - What changes have occurred over time?

As stated previously, ten children completed more than one Social Network Map, two of whom completed three. No conclusions can be drawn as yet regarding the outcomes of the Take Two program’s efforts to strengthen children’s social networks although the preliminary findings are positive. However, they provide rich case studies as to what positive outcomes may look like in individual cases. In terms of their representative nature compared to the general Take Two client group, all the repeat Social Network Maps were undertaken via three rural teams and so cannot be used to describe the outcomes of the program more broadly.

The mean age of these children at the time of the first Social Network Map was 10 years (range = 8 to 15 years). More males (70%) completed repeat measures, consistent with the broader Take Two population. Two children (20%) were Aboriginal. Eight (80%) were in some form of out-of-home care at the time of completing the first Social Network Map. According to information analysed from the Child Protection records at the time of referral to Take Two, seven of the children had experienced multiple placements ($M = 5.6; SD = 4.4; range = 1 to 12 placements).

These cases were examined for changes over time. Tracy (1990) examined the level of consistency from one time period to another, noting in her study 70 percent had the same people listed in each grid. In this present study, 42 percent people were listed in Social Network Maps over the two time periods. Those most likely to be mentioned in both time periods were family members. The differences are probably indicative of both the children’s change in school and that at least three of these children changed placement or returned home during the two time periods.

The most obvious change that occurred in all but two cases was that the children described people in their network as closer (80%) in the last grid. Figure 37 from the first to the last Social Network Map.

Figure 38 on page 107 shows the percentage of those the children described as ‘very close’ from the first to the last Social Network Map.

Figure 37. Mean percentage of people described in children’s Social Network Map as ‘very close’ over two time periods (N = 10)

<table>
<thead>
<tr>
<th>Ten cases over two time periods</th>
<th>Very close - Time 1</th>
<th>Very close - Time 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>17%</td>
<td>47%</td>
</tr>
<tr>
<td>2</td>
<td>32%</td>
<td>47%</td>
</tr>
<tr>
<td>3</td>
<td>27%</td>
<td>27%</td>
</tr>
<tr>
<td>4</td>
<td>51%</td>
<td>97%</td>
</tr>
<tr>
<td>5</td>
<td>60%</td>
<td>56%</td>
</tr>
<tr>
<td>6</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>7</td>
<td>93%</td>
<td>64%</td>
</tr>
<tr>
<td>8</td>
<td>73%</td>
<td>87%</td>
</tr>
<tr>
<td>9</td>
<td>92%</td>
<td>93%</td>
</tr>
<tr>
<td>10</td>
<td>100%</td>
<td>92%</td>
</tr>
</tbody>
</table>

Figure 38. Mean percentage of network described as ‘very close’ over two time periods (N = 10)
For these ten children, there was a small increase of the mean percentage of those who provided emotional support over the two time periods (42% in first time period and 47% in last time period). A larger increase was seen in the mean percentage of those who provided information (increased from 36% to 56%). There was a slight decrease in those who provided practical assistance (35% to 33% over two time periods). These patterns will be interesting to examine over a longer time period and with a larger data set.

In the two cases where the child completed three Social Network Maps over time, the first and last grids were used in the analysis. However, the intermediate grids were informative in telling aspects of the children’s story. For example, one child who completed three maps initially lived with both parents, then with his father, and finally with his mother. The interim period was the time of most instability for him where it was unclear what the long-term plans were. In this second grid, his Social Network Map made no reference to family or household, but concentrated on friends and teachers.

In another case, the child had moved from foster care at the time of the first grid to residential care at the time of the last two grids. In between the second and third time she changed from Primary School to Secondary School. Over the three Social Network Maps completed by this child the observable patterns related to these changes within the school and placement.

The following is a case vignette of a boy called Neil who completed two Social Network Maps approximately a year apart. The Social Network Maps are shown as Figure 39.

Neil is a 12-year-old boy who lived in foster care for three years. In the first Social Network Map it was unclear how often he saw his mother, whom he described as ‘hardly ever’ providing emotional or practical support. He saw his brother monthly where he both gave and received help and who ‘almost always’ provided emotional and practical support. The only people he described in his life as ‘very close’ were his carers. He was aware of the support he received from the foster care worker and a friend. Most others were on the outer rim of his life, including his mother. Even though he described them as ‘not very close’, he believed his teachers ‘almost always’ provided him with emotional and practical support. He described the Take Two clinician and a doctor as ‘not very close’ and ‘hardly ever’ providing emotional or practical support and another doctor as ‘not very close’ but sometimes providing emotional and practical support.

A year later, Neil completed a second Social Network Map as well as other outcome measures. By this time he had returned to live with his mother, whom he now described as ‘very close’ and ‘almost always’ providing emotional and practical support. Although the number of people he listed in his network had reduced in size, the majority had moved from being ‘not very close’ to ‘sort of close’. In addition to reuniting with this mother during the intervening time period, Neil had transitioned from Primary to Secondary School. Compared to his first Social Network Map there is no reference to teachers and his friendships have changed. He continues to list a number of professionals, whom he now describes as ‘sort of close’ and ‘sometimes’ providing emotional and practical support.
Figure 39. Social Network Map - Neil at 11 years then 12 years of age
7.13 Summary
The Social Network Map is one way to facilitate children presenting their world as they perceive it. Children who become part of the child protection system often have little say as to who is in their world. Completing a Social Network Map gives them an opportunity to describe their social world. The interpretation of what they describe in these maps needs to be made with them by their clinician; however, even taking the completed map at face value provides a snapshot of their perceptions.

The absence of parents and the presence of siblings is one of the themes from this analysis. The results provide useful information regarding the client group and their service system. Certainly the place of teachers supports the importance of schools in the lives of these children.

The findings from the Social Network Maps need to be treated cautiously, given the relatively low number of respondents, especially as the measure is not standardised. However, as an indication of how the child perceives his or her formal and informal networks the Social Network Map is valuable. The inclusion of such a measure has enabled a new way to explore and illustrate the social world of children in their own eyes. Furthermore, the Social Network Map provides a measure of change occurring in the child’s networks over time and evidence of this change is important in exploring the impact of Take Two. Work is being done to clarify definitions and standardise the administration of the Social Network Map within Take Two. In addition exploration of associations with results of other outcomes measures will be explored at a later stage.
Chapter 8: Outcomes - Emotional and behavioural symptoms

8.1 Overview
The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997) is a standardised measure of positive and negative aspects of psychological adjustment and behaviour for children. There are three different versions of the SDQ, a self-report version completed by young people, a parent version completed by both parents and carers, and a teacher version. Each version is made up of four difficulties scales: emotional symptoms, conduct problems, hyperactivity/inattention and peer relationship problems. These scales are then combined to generate a total difficulties score. In addition to the difficulties scales there is also a strengths scale measuring prosocial behaviour. This chapter provides preliminary data based on analysis of the SDQ, both in terms of gaining a picture of the level and type of difficulties and whether or not change is found.

8.2 Demographic data and response rate
The SDQs were completed by the young people (11 years and older), parents, carers and teachers. In total 488 SDQs were completed in relation to 172 children.

Of the 172 children:
- 68% were male.
- At time of first or only measure, the average age was 10.9 years ($SD = 3.4$). Age range was 4 to 17 years; 54% were aged between 9 and 15 years.
- 14% were Aboriginal.
- 41% were in home-based care, 22% were in residential care, 15 percent were in kinship care and 14% were living with one or both parents. The remaining 7% were in other types of placement at time of referral.
- 39% were a client of a rural team, 40% were a client of a metropolitan team, 12% were Secure Welfare clients and 2% were clients of the Aboriginal team.

Compared to the general Take Two population, the children who completed or were the subject of an SDQ were more likely to be male and living in home-based care, such as foster care. They were less likely to be living in residential care or with their parent/s and less young people were clients of Secure Welfare.

As shown in Table 28, 122 of the 488 (25%) measures were completed by the young person, 64 were completed by parents (13%), and 142 (29%) were completed by carers. Teachers completed 154 SDQs (32%). The remaining SDQs were completed by case workers, a childcare worker, and a case manager. As also shown in Table 28, a number of the baseline SDQs were completed at the review phase. However baseline SDQs were increasingly completed within the first six months of Take Two involvement, especially after October 2004 when the training on outcome measures was provided to Take Two staff.

<table>
<thead>
<tr>
<th>SDQ phase</th>
<th>Respondent</th>
<th>Secure Welfare</th>
<th>Assessment</th>
<th>Review(s)</th>
<th>Closure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>Young person</td>
<td>20</td>
<td>36</td>
<td>31</td>
<td>7</td>
<td>94</td>
</tr>
<tr>
<td>1st</td>
<td>Parent</td>
<td>1</td>
<td>29</td>
<td>21</td>
<td>6</td>
<td>57</td>
</tr>
<tr>
<td>1st</td>
<td>Carer</td>
<td>0</td>
<td>53</td>
<td>48</td>
<td>9</td>
<td>110</td>
</tr>
<tr>
<td>1st</td>
<td>Teacher</td>
<td>4</td>
<td>54</td>
<td>43</td>
<td>12</td>
<td>113</td>
</tr>
<tr>
<td>1st</td>
<td>Other</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>2nd</td>
<td>Young person</td>
<td>22</td>
<td>2</td>
<td>2</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>2nd</td>
<td>Parent</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd</td>
<td>Carer</td>
<td>19</td>
<td>11</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd</td>
<td>Teacher</td>
<td>27</td>
<td>10</td>
<td>37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd</td>
<td>Other</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd</td>
<td>Young person</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd</td>
<td>Parent</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd</td>
<td>Carer</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd</td>
<td>Teacher</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd</td>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>25 (5.1%)</td>
<td>175 (35.9%)</td>
<td>224 (45.9%)</td>
<td>64 (13.1%)</td>
<td>488</td>
</tr>
</tbody>
</table>

Note. Assessment phase was calculated as within 6 months of referral and closure phase was calculated as within 6 months of closure date.
The 122 self-report SDQs were completed by 95 young people. There were 72 young people who completed just the one measure, 18 young people completed two measures and five young people completed three measures over different time periods. The 64 parent SDQs were completed by 57 different parents in relation to 52 children. Sixty-four percent of these measures were completed by mothers, 12 percent by fathers and the remaining by step-parents, two parents/step-parents or it was unknown which parent completed the SDQ. The 142 carer SDQs were completed by 116 carers in relation to 91 children. The 154 teacher SDQs were completed by 140 teachers in relation to 103 children.

There was a 48 percent response rate in relation to the young people completing the SDQ. A response rate assumes that the completion of the SDQ is mandatory after the date of implementation in October 2004. Some further allowance was given for cases closing within six months of this date of implementation. In terms of understanding the response rate, it is consistent with other programs initiating outcome measures, where there is a period of time for such measures to be embedded in practice. Clinicians may also use their discretion in administering the measures, such as if they believe a child is not developmentally ready or if the parent has limited contact with the child. Furthermore the young people and those in their social networks may refuse to complete a measure. One example of this is a young woman who completed the SDQ herself, but insisted that the measure not be given to anyone else to complete.

8.3 Baseline data regarding the children completing an SDQ

Baseline data consisted of all SDQ measures completed by a respondent for the first time, unless this was within six months of closure and the case had been open for more than six months. These were described as the first set in the previous Table 28.

8.3.1 Scales reported in the clinical or borderline range

Figure 40 shows the number of scales at the clinical and borderline level for each respondent type. Eighty-three percent of young people had one or more SDQ scales at the borderline or clinical level. The majority of young people reported having two or three scales at the borderline or clinical level (53%). Among parents 98 percent reported that children had one or more scales at a level of concern. Over two thirds (68%) of parents reported that their children had three or more scales at the borderline or clinical level. Carers reported that 95 percent of children in their care had one or more scales in the borderline or clinical range, and that 58 percent had more than three scales in this range. Eighty-eight percent of teachers reported that children had one or more scales in the borderline or clinical range and 63 percent reported that children had three or four scales in the borderline or clinical range. As seen in Figure 40, young people and teachers were more likely to report no clinical or borderline scales and alternatively were less likely to report all five scales at this level of concern.

Table 29 shows that the majority of young people report borderline or clinical levels for conduct problems (62%) and hyperactivity/inattention (63%). According to the young person SDQs, the majority had a total difficulties score in the borderline or clinical range (56%). Both parents and carers reported that the majority of children have borderline or clinical levels on all scales and the total difficulties score, except prosocial behaviour. According to teachers, the majority of children experienced difficulties in all areas except emotional symptoms. Teachers were the only group who reported more than half the children as having problems with an absence of prosocial behaviours, although carers were close to half. These findings demonstrate that children are experiencing difficulties in multiple settings, namely home, placement and school. However, teachers are less frequently identifying emotional symptoms for the children, compared to parents or carers.
When comparing across respondent groups, there were significant differences for all scales except hyperactivity. Young people were less likely to report that they were in the clinical range on most scales compared to their parents, carers and/or teachers. Young people and teachers were significantly less likely to report in the borderline or clinical range for emotional symptoms ($X^2(3) = 40.53, p < .001$) compared to parents and carers. Young people were significantly less likely to report experiencing conduct problems compared with their carers ($X^2(3) = 17.63, p < .01$). Peer problems were identified as a concern significantly more often among parents and carers than by the young people ($X^2(3) = 32.14, p < .001$). Young people were significantly less likely to report concerns in relation to prosocial behaviour compared with teachers ($X^2(3) = 19.71, p < .001$). A comparison of these data reveal that parents, carers and teachers are significantly more likely to report the children in the borderline or clinical range in the total difficulties than young people ($X^2(3) = 19.74, p < .001$). As the data set grows it will be possible to triangulate responses across the different respondent types regarding the same child.

8.3.2 Other questions relating to difficulties

The SDQ also includes questions regarding whether the respondent thinks the young person experiences difficulties and if so, enquires further about chronicity, distress, social impairment and burden to others.

Severity of difficulties

As shown in Table 30, nearly half (45%) of the young people reported that they had definite or severe difficulties, with 17 percent reporting that they had no problems. Two thirds (68%) of parents reported that their children had definite or severe difficulties and two percent reported that they had no difficulties. Three quarters of the carers (76%) reported that the children had definite or severe difficulties with nearly half reporting that the difficulties were severe. Four fifths (79%) of the teachers reported that the children had definite or severe difficulties, although similarly to parents and young people they noted more children as having definite difficulties compared to severe difficulties. Carers were the respondents who most frequently noted that the difficulties were severe, followed by teachers.

<table>
<thead>
<tr>
<th>Table 29</th>
<th>Baseline Data: Percentage of Children and Young People in the Normal, Borderline and Clinical Range on Scales of the SDQ as Reported by Young People, Parents, Carers and Teachers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent</td>
<td>SDQ Scale</td>
</tr>
<tr>
<td>Young person (n = 87)</td>
<td>Emotional symptoms</td>
</tr>
<tr>
<td></td>
<td>Conduct problems</td>
</tr>
<tr>
<td></td>
<td>Hyperactivity</td>
</tr>
<tr>
<td></td>
<td>Peer problems</td>
</tr>
<tr>
<td></td>
<td>Prosocial behaviour</td>
</tr>
<tr>
<td></td>
<td>Total difficulties</td>
</tr>
<tr>
<td>Parent (n = 45)</td>
<td>Emotional symptoms</td>
</tr>
<tr>
<td></td>
<td>Conduct problems</td>
</tr>
<tr>
<td></td>
<td>Hyperactivity</td>
</tr>
<tr>
<td></td>
<td>Peer problems</td>
</tr>
<tr>
<td></td>
<td>Prosocial behaviour</td>
</tr>
<tr>
<td></td>
<td>Total difficulties</td>
</tr>
<tr>
<td>Carer (n = 90)</td>
<td>Emotional symptoms</td>
</tr>
<tr>
<td></td>
<td>Conduct problems</td>
</tr>
<tr>
<td></td>
<td>Hyperactivity</td>
</tr>
<tr>
<td></td>
<td>Peer problems</td>
</tr>
<tr>
<td></td>
<td>Prosocial behaviour</td>
</tr>
<tr>
<td></td>
<td>Total difficulties</td>
</tr>
<tr>
<td>Teacher (n = 92)</td>
<td>Emotional symptoms</td>
</tr>
<tr>
<td></td>
<td>Conduct problems</td>
</tr>
<tr>
<td></td>
<td>Hyperactivity</td>
</tr>
<tr>
<td></td>
<td>Peer problems</td>
</tr>
<tr>
<td></td>
<td>Prosocial behaviour</td>
</tr>
<tr>
<td></td>
<td>Total difficulties</td>
</tr>
</tbody>
</table>
Respondents who answered ‘Yes’ to the difficulties question were asked how long the difficulties had been present (see Table 31) and a series of questions in relation to the impact of these difficulties (see Table 32).

**Chronicity of problems**

In relation to chronicity of problems, all respondent groups reported a majority of children had been experiencing difficulties for over a year (see Table 31). The size of the majority was smaller among carers and teachers. This is likely to be at least in part due to some carers and teachers not knowing the children for longer, thereby being unable to comment on the chronicity of problems. This was noted on several of the SDQs.

**The impact and burden of the problems**

The impact question refers to how much of an impact the respondent considers the difficulties have had on the child’s life. The impact score ranges from zero to ten (0 to 6 for the teacher SDQ). A score of one is considered in the borderline range and a score of two is considered to be of clinical importance. Table 32 shows the level of impact that the reported difficulties have on the children. The majority of young people reporting difficulties considered that their difficulties significantly impacted on their daily life (58%). Parents (86%), carers (83%) and teachers (77%) all reported a large majority of children for whom their difficulties impacted on their daily life at a clinical level.

<table>
<thead>
<tr>
<th>Table 30</th>
<th>Baseline Data: Overall Difficulties Ratings on the Strengths and Difficulties Questionnaire (SDQ) as Reported by the Young Persons, Parents, Carers and Teachers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent</td>
<td>No difficulties (%)</td>
</tr>
<tr>
<td>Young person (n = 84)</td>
<td>16.7</td>
</tr>
<tr>
<td>Parent (n = 47)</td>
<td>2.1</td>
</tr>
<tr>
<td>Carer (n = 90)</td>
<td>4.4</td>
</tr>
<tr>
<td>Teacher (n = 92)</td>
<td>4.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 31</th>
<th>Baseline Data: Responses to the SDQ Question ‘How Long have these Difficulties been Present?’ as Reported by the Young Persons, Parents, Carers and Teachers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent</td>
<td>Less than a month (%)</td>
</tr>
<tr>
<td>Young person (n = 70)</td>
<td>7.1</td>
</tr>
<tr>
<td>Parent (n = 39)</td>
<td>0.0</td>
</tr>
<tr>
<td>Carer (n = 58)</td>
<td>1.7</td>
</tr>
<tr>
<td>Teacher (n = 72)</td>
<td>6.9</td>
</tr>
</tbody>
</table>
Another question on the SDQ asks about the burden of these difficulties on others, such as family, friends and school. As shown in Table 33 half of the young people reported that their difficulties made it a ‘medium’ or ‘a great deal’ harder for those around them (49%). This figure was higher when parents (67%), carers (65%) and teachers (62%) responded.

### Table 33
Baseline Data: Responses to the SDQ question 'Do the Difficulties put a Burden on You or the Family?' as Reported by the Young Persons, Parents, Carers and Teachers

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Not at all (%)</th>
<th>A little (%)</th>
<th>A medium amount (%)</th>
<th>A great deal (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young person</td>
<td>17.4</td>
<td>33.3</td>
<td>20.3</td>
<td>29.0</td>
</tr>
<tr>
<td>(n = 69)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>17.3</td>
<td>15.2</td>
<td>15.2</td>
<td>52.2</td>
</tr>
<tr>
<td>(n = 46)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer</td>
<td>13.6</td>
<td>21.0</td>
<td>28.3</td>
<td>37.0</td>
</tr>
<tr>
<td>(n = 81)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teacher</td>
<td>17.2</td>
<td>20.7</td>
<td>24.1</td>
<td>37.9</td>
</tr>
<tr>
<td>(n = 87)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. For the young person version this question was phrased ‘Do the difficulties make it harder for those around you (family, friends, teachers etc)?’ And for the teacher version the question was ‘Do the difficulties put a burden on the class as a whole?’

### 8.3.3 Comparison with other studies

The third evaluation report will compare data regarding the Take Two client group with the CAMHS population as both services use the SDQ. In the interim it has been useful to compare the Take Two client group with some of those described in a couple of published studies. For example, Mathai, Anderson, and Bourne (2002) undertook a study of a sample of CAMHS clients in Melbourne, Victoria. This study involved a comparable sample size to this report (young people: n = 49; parents: n = 130; and teachers: n = 99). They did not distinguish between parents and carers though it can be assumed that most were parents.

The young people in the CAMHS study (Mathai, Anderson, & Bourne, 2002) reported more clinically elevated scores in all the scales compared to the findings in this present study (e.g. total difficulties score in the Take Two study was 35% compared to 68% in the CAMHS study). This is consistent with referrals to CAMHS focusing on specific presentation of mental health concerns (DHS, 2006) compared to Take Two, where this may be part of their presentation but the focus is usually on their experience of abuse and neglect.

The pattern across scales was similar in both studies where young people reported themselves most frequently in the clinical range for conduct problems (53% in this study and 71% in the CAMHS study by Mathai, Anderson, & Bourne, 2002). Comparing across the scales, in both studies the young people reported themselves least frequently as having peer problems (14% in this study and 32% in the CAMHS study) or lack of prosocial behaviours (15% in this study and 32% in the CAMHS study).

There was less of a difference between the parent reports in the Take Two study compared to the Mathai, Anderson, and Bourne (2002) CAMHS study; however, in general, the CAMHS study found parents reported the children more frequently being in the clinical range. This is evidenced by the total difficulties score by parents, where in this study it was 69 percent and in the CAMHS study it was 85 percent. Again both studies found that parents reported conduct problems
as the most frequent problems in the clinical range (73% in this study compared to 78% in the CAMHS study). They were also similar in that the lack of prosocial behaviours was the least frequently reported concern in both studies (20% in this study and 38% in the CAMHS study).

Interestingly, teacher reports of clinical scores showed a different pattern across the two studies. Teachers more frequently reported the children in the clinical range in the Take Two study compared to the CAMHS study, except for emotional problems. Sixty-six percent were in the clinical range for the total difficulties score for the Take Two study compared to 60 percent in the CAMHS study. There was also a different pattern of which problems were rated more frequently in the clinical range. The Take Two study found that teachers reported children most frequently as having conduct problems (65%), followed by problems with hyperactivity (60%). The CAMHS study found that teachers reported the children most frequently as having problems with hyperactivity (49%), followed by conduct problems (41%). Both studies found that emotional problems were the least frequently reported by teachers (14% in this study and 32% in the CAMHS study).

Mount, Lister, and Bennum (2004) undertook a study in the United Kingdom of 50 young people in out-of-home care and their carers. Their sample was slightly smaller and different to the Take Two population as it did not include children under the age of ten years, nor children living with their families. Nevertheless it provides an interesting point of comparison.

Similar to that found in the present study on Take Two, the UK study (Mount, Lister, & Bennum, 2004) noted that carers perceived the young people as more frequently having clinically elevated scores than the young people themselves. Another similarity was the pattern of young people’s responses, where they most frequently reported themselves in the clinical range regarding conduct problems (53% in the Take Two study and 42% in the UK study) and least frequently for peer relationship difficulties (14% in this study and 6% in the UK study). Except for prosocial behaviours, this present study found more young people reported themselves in the clinical range than the UK study (for example, total difficulties score was 35% in this study and 20% in the UK study). However, when combining the borderline and clinical scores this difference between the two studies was no longer apparent.

8.4 Analysis of changes in emotional and behavioural difficulties over time

Due to the small numbers of measures that were completed at three or more time periods, this analysis primarily is based on measures completed at the first and second time period. However, when a third or fourth measure is available from the same type of respondent, this score is used instead of Time 2.

There were 22 young people who had completed an SDQ on two occasions (four on three occasions). Seven parents, all of whom were mothers, completed an SDQ on two occasions. Twenty-one carers completed an SDQ on two occasions, six of whom also completed a third measure at a later time. There were a small number of carers and parents who completed a second or third measure about a child; yet were not the same as those who had completed the previous measure. For example, in one case a carer completed the first SDQ, but at the time of review the child had been returned home and so the parent completed the second measure. In another case there were three SDQs completed over three time periods, each by a different carer. For this analysis, when SDQs were completed by a different parent or carer they were not included in the repeat measure analysis.

Thirty-five children had teachers complete an SDQ on two occasions, four of whom had a third measure completed. However, these were often not the same teachers, given the pattern of children changing grades and schools. Different teachers over time were still included in this study of repeat measures given the common nature of such changes, which made comparisons with other studies possible. When the same teacher had completed two or more measures over time, these were the ones included in the analysis. When multiple teachers completed SDQs at the same time period, those for whom it appeared they had the main teaching role for the child were included in this repeat measure analysis.

As shown in Table 34, the percentage of children described in the borderline or clinical range in the total difficulties score reduced over time, according to the young person, parents, carers and teachers. As seen with the young persons’ version, the frequency of the young people in the clinical range reduced over time for most of the scales and total difficulties score. It remained the same level for peer problems and prosocial behaviours.

For the parents there were reductions in the percentage who reported their children in the borderline or clinical range for every scale, except prosocial behaviour which remained the same. Carers reported reduction in problems in every scale. Teachers were the only group of respondents where two of the scales increased over time in terms of frequency of children reported in the borderline or clinical range (i.e. emotional problems and peer problems). The other scales and the total difficulties score reduced according to the teachers over the two time periods.
When comparing across the different scales, regardless of respondent type, hyperactivity problems had the most noted change, followed by conduct problems.

When comparing the mean scores over the two time periods, tests of significance (t-tests) revealed the following:

- No significant difference according to the young persons’ report or the parents report between the mean scores at baseline compared to follow-up.
- According to the carers’ reports, there was a significant mean reduction in conduct problems and hyperactivity/inattention problems over time ($t(20) = 2.16, p < .05$ and $t(20) = 2.18, p < .05$ respectively).
- Carers reported a significant reduction in mean scores for the total difficulties score ($t(20) = 2.17, p < .05$).
- When looking at the mean scores, carers noted a slight, but not significant, increase in emotional symptoms and concerns regarding prosocial behaviours.
- There were no significant changes over time according to the teachers’ reports, with a slight, but not significant, increase in emotional symptoms noted. In fact the least amount of change was noted in the teachers’ reports. This could be explained by the fact that, unlike the other informants, the teachers were not a matched sample. While this approach was necessary as the teacher who is best able to complete the SDQ often changes over time, it does increase the variability in responses.

Figure 41 shows the direction of change for the total difficulties score was towards improvement over time by all respondent types, except teachers who showed no change.

---

<table>
<thead>
<tr>
<th>Respondent</th>
<th>SCQ Scale</th>
<th>Time 1 %</th>
<th>Time 2 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young person (n = 22)</td>
<td>Emotional symptoms</td>
<td>18.2</td>
<td>4.5</td>
</tr>
<tr>
<td></td>
<td>Conduct problems</td>
<td>50.0</td>
<td>40.9</td>
</tr>
<tr>
<td></td>
<td>Hyperactivity</td>
<td>54.5</td>
<td>50.0</td>
</tr>
<tr>
<td></td>
<td>Peer problems</td>
<td>27.3</td>
<td>27.3</td>
</tr>
<tr>
<td></td>
<td>Prosocial behaviour</td>
<td>13.6</td>
<td>13.6</td>
</tr>
<tr>
<td></td>
<td>Total difficulties</td>
<td>45.5</td>
<td>31.8</td>
</tr>
<tr>
<td>Parent (n = 7)</td>
<td>Emotional symptoms</td>
<td>100</td>
<td>71.4</td>
</tr>
<tr>
<td></td>
<td>Conduct problems</td>
<td>57.1</td>
<td>42.9</td>
</tr>
<tr>
<td></td>
<td>Hyperactivity</td>
<td>71.4</td>
<td>28.6</td>
</tr>
<tr>
<td></td>
<td>Peer problems</td>
<td>100</td>
<td>85.7</td>
</tr>
<tr>
<td></td>
<td>Prosocial behaviour</td>
<td>28.6</td>
<td>28.6</td>
</tr>
<tr>
<td></td>
<td>Total difficulties</td>
<td>85.7</td>
<td>71.4</td>
</tr>
<tr>
<td>Carer (n = 21)</td>
<td>Emotional symptoms</td>
<td>42.8</td>
<td>38.1</td>
</tr>
<tr>
<td></td>
<td>Conduct problems</td>
<td>95.2</td>
<td>76.2</td>
</tr>
<tr>
<td></td>
<td>Hyperactivity</td>
<td>90.5</td>
<td>57.2*</td>
</tr>
<tr>
<td></td>
<td>Peer problems</td>
<td>85.7</td>
<td>71.4</td>
</tr>
<tr>
<td></td>
<td>Prosocial behaviour</td>
<td>52.4</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>Total difficulties</td>
<td>85.7</td>
<td>66.6</td>
</tr>
<tr>
<td>Teacher (n = 35)</td>
<td>Emotional symptoms</td>
<td>11.4</td>
<td>17.1</td>
</tr>
<tr>
<td></td>
<td>Conduct problems</td>
<td>74.3</td>
<td>68.6</td>
</tr>
<tr>
<td></td>
<td>Hyperactivity</td>
<td>68.6</td>
<td>62.9</td>
</tr>
<tr>
<td></td>
<td>Peer problems</td>
<td>45.7</td>
<td>51.4</td>
</tr>
<tr>
<td></td>
<td>Prosocial behaviour</td>
<td>57.1</td>
<td>51.4</td>
</tr>
<tr>
<td></td>
<td>Total difficulties</td>
<td>74.3</td>
<td>68.6</td>
</tr>
</tbody>
</table>

* Significant at .05 level
8.5 Questions relating to the helpfulness of the service

Two questions relating to whether the service had been helpful were asked on the follow-up versions of the SDQ. Although most of these were completed as part of the repeated measure process (i.e. at time 2 or 3), some respondents completed this version of the SDQ as their first measure. For example, some respondents completed their first SDQ at time of review or closure, especially for cases referred to Take Two in 2004. Where there were multiple informants in the same category, such as two carers, the most recent result was used. When they were completed at the same time, the majority view was recorded. Follow-up SDQs that were erroneously completed at time of initial assessment were excluded, except in relation to Secure Welfare given the brevity of that service’s involvement.

As shown in Table 35, 75 percent of young people reported that their problems were better (either ‘a bit’ or ‘much’) since coming to Take Two. A smaller percentage, but still a clear majority (65%), found Take Two had been helpful in other ways such as providing information or making problems more bearable. Over half (57%) of the parents reported that the children’s problems were improving since Take Two involvement. Carers reported the highest percentage of children whose problems had improved (79%). Teachers reported that 64% of the children showed some level of improvement in their difficulties since becoming involved with Take Two.

In relation to the question of whether the service has been helpful in other ways, more than two thirds of all respondent types reported that Take Two had been helpful. Those who commented more frequently about Take Two being helpful were carers (76%), followed by parents and teachers (71% each) and then the young people (65%).
There is a strong positive correlation between responses to these two questions indicating that those who reported the young person’s problems were better since coming to Take Two. Responses also indicated that coming to the service had been useful in other ways ($r = .65, p < .001$ for young person; $r = .65, p < .05$ for parent; $r = .60, p < .001$ for carer). The only exception to this was that the correlation between these two questions was not significant for teachers.

### 8.6 Summary

Regardless of who was the respondent to the SDQ, all recognised that the children were experiencing real difficulties. Young people, parents, carers and teachers all reported a total difficulties score in the borderline or clinical range for the majority of children at the time of first completing the SDQ. Among all respondents, the majority reported multiple scales at the borderline or clinical level at the time of first completing the SDQ. Young people were the group less frequently reporting themselves in the borderline and clinical range and this is consistent with other studies. All types of respondents reported that the difficulties experienced by the children had a clinical level of impact on daily functioning. The difference found between respondents is of interest as it illustrates the varying perspectives of the children’s presentation at the same time.

There was only some statistically significant change over time involved with Take Two as reflected in the SDQ, particularly the carers’ perceived improvement in hyperactivity and conduct problems. A finding consistent with the changes of scales over time was the majority of responses who agreed that Take Two had been helpful and that the child’s problems had improved.

This preliminary analysis of the SDQ data pertaining to Take Two clients provides a useful platform to build a picture of the nature of difficulties experienced by this client group and whether or not change has been found. Further analysis will also occur in relation to the multiple respondents, such as by triangulating results across different respondents regarding the same children. Such data provide useful information both for clinical and research purposes.

<table>
<thead>
<tr>
<th>Table 35</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questions on the Follow-up SDQ relating to whether Take Two Intervention has been Helpful</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Since coming to the service are the child’s problems:</th>
<th>Much worse (%)</th>
<th>A bit worse (%)</th>
<th>About the same (%)</th>
<th>A bit better (%)</th>
<th>Much better (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young person (n = 32)</td>
<td>3.1</td>
<td>3.1</td>
<td>18.8</td>
<td>34.4</td>
<td>40.6</td>
</tr>
<tr>
<td>Parent (n = 14)</td>
<td>7.1</td>
<td>14.3</td>
<td>21.4</td>
<td>28.6</td>
<td>28.6</td>
</tr>
<tr>
<td>Carer (n = 42)</td>
<td>2.4</td>
<td>1.8</td>
<td>19</td>
<td>40.5</td>
<td>38.1</td>
</tr>
<tr>
<td>Teacher (n = 36)</td>
<td>5.6</td>
<td>5.6</td>
<td>25</td>
<td>38.9</td>
<td>25</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Has coming to the service been helpful in other ways; e.g. providing information or making the problems more bearable?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Not at all (%)</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>Young person (n = 31)</td>
</tr>
<tr>
<td>Parent (n = 14)</td>
</tr>
<tr>
<td>Carer (n = 42)</td>
</tr>
<tr>
<td>Teacher (n = 35)</td>
</tr>
</tbody>
</table>
Chapter 9: Outcomes - Trauma symptoms

9.1 Overview

It has become increasingly important in the context of vulnerable children, such as those in the protection and care system to have an informed understanding of the impact of trauma. The Trauma Symptom Checklist for Children (TSCC) (Briere, 1996) was selected by Take Two to assess the impact of exposure to traumatic events and the effects of trauma on children. The TSCC has a series of scales which reflect different aspects of traumatisation including anger, anxiety, depression, posttraumatic stress symptoms, dissociation and sexual concerns. This chapter provides a preliminary look at these data in terms of the level of concerns at baseline and a preliminary analysis of change over time.

9.2 Description of the Trauma Symptom Checklist for Children (TSCCs) completed

9.2.1 Number and timing of TSCCs completed

There were 160 TSCCs administered to 116 children with the following demographic description:

- 62% were male;
- 48% were between the ages of 8 and less than 12 years; 52% were between the ages of 12 and 17 years;
- 15% were Aboriginal;
- 45% were from a rural team, 35% from a metropolitan team, 19% from Secure Welfare and 2% were from the Aboriginal team; and
- 38% were in home-based care; 22% were in residential care; 17% were living with one or both parents; 16% were living in kinship care and 8% were in some other type of placement at time of referral to Take Two.

There were slightly more males than in the general Take Two population and the rural teams were more highly represented than among the general Take Two client group. The types of placements are consistent with the overall Take Two population with slightly more in home-based care and slightly fewer living with one or both parents. The percentage of children completing one or more TSCCs who are Aboriginal is consistent with the percentage of Aboriginal children involved with Take Two during 2004 and 2005.

It is difficult to calculate the number of TSCCs that could have been completed during this evaluation period, particularly as data were not routinely provided regarding when attempts were made to ask a child to complete a measure. As the TSCC was implemented in October 2004 (i.e. ten months after many cases had begun) it was initially discretionary in relation to cases that were soon to be closed. The other major reason for not administering the TSCC was if the child was under the age of eight years or considered otherwise developmentally not ready to complete this self-report measure. Similarly to the SDQ, administering the TSCC remained discretionary for Take Two Secure Welfare cases given the brevity and episodic nature of involvement.

Of the 160 TSCCs completed, three had substantial missing data making 157 measures available for analysis. Once Secure Welfare cases, younger children, and those cases closed before or within six months of the measures being introduced were excluded, there was a 36 percent completion rate. This equated to 94 children attempting or completing one or more TSCC.

In introducing the TSCC as an outcome measure, Take Two recognised that completion of the measure would not always be possible. For example, separate to the 94 children who completed a measure, there were 19 cases where clinicians reported reasons for not administering the TSCC. These included minimal direct work with the child or the child refusing to do the measure.

9.2.2 Validity of TSCCs completed

When analysing psychometric measures it is important to determine if there is sufficient data or other indicators within a measure in order for it to be valid. The TSCC includes two validity scales which indicate that if a certain number of particularly common or rare responses are provided it is considered to be invalid, based on statistical analysis of the normative data.

<table>
<thead>
<tr>
<th>Table 36</th>
<th>Number of TSCCs completed at different stages during Take Two involvement (N = 160 TSCCs by 116 children)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Secure Welfare only</td>
</tr>
<tr>
<td>1st TSCC</td>
<td>22 (18.8%)</td>
</tr>
<tr>
<td>2nd TSCC</td>
<td>28 (77.8%)</td>
</tr>
<tr>
<td>3rd TSCC</td>
<td>3 (42.9%)</td>
</tr>
<tr>
<td>Total</td>
<td>22 (13.8%)</td>
</tr>
</tbody>
</table>

Note. Assessment phase was calculated as within 6 months of referral and closure phase was calculated as within 6 months of closure date.
Of the 157 TSCC's available for analysis for this report, 127 were valid (81%). This percentage of valid responses is higher than the Stargate data where 69 percent were valid (Milburn, 2004). The difference between the number of valid responses between Stargate and Take Two may be influenced by the average age of children being older in Take Two. This hypothesis is based on the finding that older children in the Take Two sample were more likely than the younger children to have completed a valid measure. Another hypothesis is that the difference may relate to the different phases in the children's life that the programs have become involved in. For example, the proximity of separation for the children from their parents was greater in the Stargate program than the overall client group of Take Two. It is unknown if this or other variables may be a factor or if the difference will not be as apparent over time. This will require further exploration as more TSCCs are completed.

Nineteen (12%) TSCC profiles were invalid due to under-endorsement of items indicative of denial or minimisation of difficulties. For example, if a child selects 'never' for a certain number of items such as having nightmares, daydreaming and feeling sad or unhappy, then the measure is considered invalid based on statistical analysis of the normative data. This applies both to children with and without a trauma history, so does not imply an absence of abuse or other trauma. Briere and Elliott (1997) found that an invalid profile due to under-endorsement often occurred among children with a known trauma history but who denied such trauma.

The remaining ten invalid profiles (6%) were invalid due to over-endorsement of items. Over-endorsement occurs when a child selects 'almost all of the time' for a certain number of items for which this response is rare. A profile that is invalid due to over-endorsement of items does not imply that the respondent has not suffered abuse or other trauma, but rather that due to their unusual response pattern, meaningful interpretation cannot be made.

As mentioned previously, invalid profiles were significantly more likely to be returned by the younger of the two age groups. Twenty-four percent of 8 to 12-year-old profiles were invalid compared with nine percent of 13 to 17-year-old profiles. Twenty-four percent of 8 to 12-year-old profiles were invalid compared with nine percent of 13 to 17-year-old profiles. Twenty-four percent of 8 to 12-year-old profiles were invalid compared with nine percent of 13 to 17-year-old profiles. Twenty-four percent of 8 to 12-year-old profiles were invalid due to over-reporting whereas the invalid profiles due to over-reporting were equally split between the two age groups (five from each age group).

The majority of invalid profiles due to under-reporting were from males (84%). In contrast, 70 percent of invalid profiles due to over-reporting were from females, yet of all completed TSCCs only 36 percent were completed by females.

Also of interest, four of the ten invalid profiles (40%) due to over-endorsement of items were profiles from female Secure Welfare clients. This accounted for all of the invalid profiles from Take Two Secure Welfare clients. As more data become available as part of the ongoing evaluation, it will be possible to analyse more of the Secure Welfare cases in relation to the TSCC, including invalid profiles.

Twenty-four of the TSCC's were completed by Aboriginal children, but a greater proportion were invalid (33% compared to 16% of non-Aboriginal children); however, this difference was not significant. None of the Aboriginal children were from Secure Welfare. Similar to the overall Take Two client group the invalid measures indicated that Aboriginal children were more likely to under-report than over-report. This will be explored more over time and is consistent with findings from other measures, such as those used by the Australian Bureau of Statistics - National Aboriginal and Torres Strait Islander Health Survey, 2004-05 (Trewin, 2006).

There were more invalid measures in the first set of measures completed per child (fairly evenly spread between under- and over-reporting) than in subsequent measures completed by each child. However, this difference was not significant.

### 9.3 Symptoms related to trauma at baseline

The following analysis relates to the valid TSCCs completed by 92 children that provide a baseline description of the children's report of posttraumatic stress and related psychological problems. Although the intention is that the first TSCC will be completed within the initial assessment period, this was not always possible during the implementation phase of the outcome measures. For example, as the TSCC was implemented ten months into the first year of operation of Take Two, there were many TSCCs (35%) that were completed seven months or later after the referral to Take Two. Most of these were cases that had been referred prior to October 2004 (X²(3) = 45.26, p < .001). Therefore, although 27 of the baseline TSCCs were completed at time of review, they are included in this part of the analysis as they were the first completed measure done by those children.

Children may experience particular groups of symptoms, such as reflected in the anger and/or anxiety scales. A clinically elevated score means these symptoms are statistically different from expected in the normal population. Of the 92 TSCCs completed, 44 percent (n = 40) had at least one scale or subscale in the clinically elevated range. For the majority of the TSCC profiles with a clinically elevated score, there were two or more scales in the clinical range (58%; n = 23). This is higher than found in the Stargate project (Milburn, 2004), where less than 25 percent showed results in the clinical range of at least one scale, and over half of those having results in the clinical range for more than one scale.

There was no significant difference between percentage of children with one or more scales in the clinical range and the child's age, gender or Aboriginal identity. There was a significant difference in relation to whether the children lived in metropolitan or rural areas. Those children in rural areas were more likely to have one or more scales in the clinical range compared to those in metropolitan areas (X²(1) = 6.45, p < .05).

As stated previously in Chapter 2, the questions included in the TSCC provide some indicator of traumatisation, not just those listed in the specific post trauma stress scale. Figure 42 shows that the most frequently clinically elevated scale was sexual concerns where 20 children (22%) were in the clinical range. This was followed by depression (n = 14; 15%); dissociation (n = 13; 14%), anger (n = 12; 13%), specific trauma symptoms (n = 9; 10%) and anxiety (n = 8; 9%).
In terms of further analysis regarding sexual concerns, 21 children (23%) were in the clinical range on the sexual preoccupation subscale and 12 children were in the clinical range on the sexual distress (13%) subscale. In relation to the two dissociation subscales, 16 children (17%) reported in the clinical range of the overt dissociation subscale, and 12 children (12%) reported in the clinical range of the dissociation-fantasy subscale.

The only significant relationship between age, gender, Aboriginal identity and type of Take Two team across the different scales and sub-scales was regarding sexual concerns. For this scale, older children were significantly more likely to be in the clinical range than children 12 years or younger ($X^2(1) = 10.34$, $p < .01$). The subscale that was significant in this area was sexual preoccupation ($X^2(1) = 8.38$, $p < .01$), indicating that these older children were showing more sexual preoccupation compared to their age group within the normal population.

The other area of significant difference was in relation to type of Take Two team. When excluding the Aboriginal team due to the small amount of data, Secure Welfare clients were more likely to report in the clinical range regarding sexual concerns ($X^2(2) = 6.88$, $p < .05$) than clients of rural or metropolitan teams and in particular, sexual preoccupation ($X^2(2) = 9.38$, $p < .01$). There was no significant difference found when analysing whether the children came from metropolitan or rural areas.

The percentage of children at baseline with clinically elevated scores as shown in Figure 42 appears lower than expected, given the known trauma histories of the children. One hypothesis is that this is an accurate representation of their traumatisation. This is inconsistent with what is known about their history of child abuse and other traumas, but needs to be acknowledged as a possibility pending further data.

Another hypothesis is that these findings may reflect that some changes have already occurred for the children prior to completing the first TSCC, especially as over a third were completed after the initial assessment period. This is supported by comparing the percentage of children in the clinical range who completed the measure within the first six months, compared to those who completed the first measure after six months involvement with Take Two. In all but the dissociation and anger scale, those who completed the measure earlier in their involvement with Take Two were more likely to score in the clinical range, though this difference was not significant. For example, in terms of those completing the first TSCC within six months of referral compared to those who completed the first measure more than six months after referral:

- 10% compared to 6% were reported in the clinical range for anxiety;
- 17% compared to 13% were reported in the clinical range for depression;
- 12% compared to 6% were reported in the clinical range for posttraumatic stress symptoms; and
- 25% compared to 16% were reported in the clinical range for sexual concerns.

A third and potentially overlapping hypothesis is that a number of these children may have under-reported their symptoms. Briere and Elliott (1997) note that some traumatised children who under-report are not so extreme as to be scored in the under-response validity scale, but nonetheless have minimised their symptoms. This highlights the importance of clinical assessment in addition to the use of such measures as the TSCC (Briere & Elliott, 1997).

Brady and Caraway (2002) found that children who experienced a higher number of types of trauma did not manifest increased symptomatology. Van der Kolk, McFarlane and Van der Hart (1996) suggest that effects of trauma, such as chronic anxiety and emotional numbing, may impede their ability to articulate internal states. Brady
and Caraway suggest that children in their study who had been multiply traumatised may have been less able to report the occurrence of symptoms, such as anger. They found a significant negative relationship between the number of types of trauma experienced and self-reported anger. Children who have experienced more types of trauma tended to report less anger than those who had experienced fewer traumas. In discussing the correlation between experience of trauma and self-reported anger, Brady and Caraway suggest that children may learn to minimise reporting on the expression of anger to avoid painful stimuli as well as a coping mechanism. These findings highlight the caution required in interpreting the findings.

9.4 Trauma symptoms - what changes have occurred over time

Twenty-four children completed a valid TSCC over at least two time periods. Five children completed a third TSCC. Where a third measure was completed this was analysed as Time 2 instead of the second measure. Two thirds (68%) of the 24 children were males and nearly two thirds were from rural teams (63%). The mean age was 11.8 years (SD = 2.2), ranging from eight to 16 years old at the time of the first TSCC. Three children (13%) were Aboriginal.

The analysis in relation to improvement of symptoms in the client group is preliminary due to the small number of valid repeat measures. However, the initial findings are promising. There was a reduction in reported symptoms in every scale from Time 1 to Time 2, although only the reduction in posttraumatic stress symptoms and anxiety were significant (Table 37). The scales close to significance were a decrease in depression and anger symptoms.

Another way of comparing change over time is to see how many children initially scored in the clinical range in one or more scales at Time 1 compared to Time 2. As shown in Table 38, every scale and subscale shows a reduction in the percentage of children in the clinical range at Time 2. However, depression is the only scale that registered as significant. This is possibly due to the small numbers in the sample.

<table>
<thead>
<tr>
<th>Table 37</th>
<th>Comparing the Mean T scores of the TSCC Scales across Time 1 and Time 2 (n = 24)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TSCC scales</td>
<td>Time 1</td>
</tr>
<tr>
<td>Anxiety *</td>
<td>M = 55.4</td>
</tr>
<tr>
<td>Depression</td>
<td>M = 55.9</td>
</tr>
<tr>
<td>Anger</td>
<td>M = 55.0</td>
</tr>
<tr>
<td>Posttraumatic stress **</td>
<td>M = 54.4</td>
</tr>
<tr>
<td>Dissociation</td>
<td>M = 55.9</td>
</tr>
<tr>
<td>Dissociation - overt subscale</td>
<td>M = 56.4</td>
</tr>
<tr>
<td>Dissociation - fantasy subscale</td>
<td>M = 53.5</td>
</tr>
<tr>
<td>Sexual concerns</td>
<td>M = 58.1</td>
</tr>
<tr>
<td>Sexual concerns - preoccupation subscale</td>
<td>M = 57.7</td>
</tr>
<tr>
<td>Sexual concerns - distress subscale</td>
<td>M = 55.9</td>
</tr>
</tbody>
</table>

* Significant at .05 level
** Significant at 0.1 level
9.5 Summary

The objective of using the TSCC as an outcome measure is to provide insight into the children’s posttraumatic symptoms and related psychological problems as an indication of change during the Take Two intervention. An additional benefit of the TSCC is that it provides useful information to the clinician to inform the therapeutic intervention and receiving feedback can assist the young people in working through their concerns. For example in a case study described in Chapter 6, it was in responding to the sexual concern-related questions that a young man began to talk about his own experience of sexual abuse.

The preliminary findings of the analysis of TSCC suggest that Take Two is making a difference in some aspects of these children’s lives. In relation to the reduction of symptoms of depression, the study of Brady and Caraway (2002) provides a useful reflection for understanding this phenomenon. They found that children who have a higher level of satisfaction regarding their discharge plan tended to report lower levels of depression. Although any findings in this study have to be speculative, it may be that Take Two intervention is giving young people more hope in their future.

The numbers are not yet sufficient to form conclusions in relation to the Take Two program; however, it should be noted that there are a number of studies (e.g. Shaw, Lewis, Loeb, Roado, & Rodriguez, 2001; Brady & Caraway, 2002) with significant findings based on similar sample size. One reason for this is that the characteristics of the children who have suffered severe abuse and/or neglect do not facilitate larger sample studies as there are many variables to take into account; and their experiences tend to be unique.

In interpreting these results there are some limitations. One limitation is that the baseline measures were taken at different times throughout Take Two involvement. This limitation will be addressed in the future as administering the TSCC begins to occur routinely at commencement of the intervention and then at scheduled review times and at closure.

Even taking the above limitations into account, these findings give strong preliminary encouragement in relation to the positive impact of Take Two interventions for the wellbeing of children.

<table>
<thead>
<tr>
<th>TSCC scales</th>
<th>Time 1 %</th>
<th>Time 2 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>16.7</td>
<td>4.2</td>
</tr>
<tr>
<td>Depression*</td>
<td>29.2</td>
<td>4.2</td>
</tr>
<tr>
<td>Anger</td>
<td>16.7</td>
<td>12.5</td>
</tr>
<tr>
<td>Posttraumatic stress</td>
<td>12.5</td>
<td>8.3</td>
</tr>
<tr>
<td>Dissociation</td>
<td>20.8</td>
<td>12.5</td>
</tr>
<tr>
<td>Dissociation - overt subscale</td>
<td>20.8</td>
<td>16.7</td>
</tr>
<tr>
<td>Dissociation - fantasy subscale</td>
<td>16.7</td>
<td>12.5</td>
</tr>
<tr>
<td>Sexual concerns (n = 23)</td>
<td>25.0</td>
<td>17.4</td>
</tr>
<tr>
<td>Sexual concerns - preoccupation subscale</td>
<td>20.8</td>
<td>17.4</td>
</tr>
<tr>
<td>Sexual concerns - distress subscale</td>
<td>20.8</td>
<td>8.7</td>
</tr>
</tbody>
</table>

* Significant at .05 level
Chapter 10: Outcomes - The child and other stakeholder perspectives

10.1 Overview
A major aspect of the design of this evaluation was to include the direct voices of the children, their parents, carers and workers involved in their lives. This was achieved primarily through the use of a stakeholder survey. The response of the young people and their parents to the survey is an important contribution to the analysis of the Take Two program. It is the beginning of what will be an ongoing process to actively elicit client feedback. Carers, including kinship carers, foster parents and residential staff, were also surveyed.

Children, parents, carers and teachers also complete one of the more structured outcome measures, such as the SDQ, but the stakeholder survey provides a more tailored approach for feedback about Take Two. It also gives a standardised approach to eliciting feedback from workers in Child Protection, Community Service Organisations and other services than the earlier calls for feedback reported in the previous evaluation report (Frederico, Jackson, & Black, 2005).

10.2 Who completed the surveys - description of sample
A total of 274 stakeholder surveys were received. This consisted of: 28 surveys from children; 29 surveys from parents (18 mothers and 11 fathers); 50 surveys from carers; and 167 surveys from workers. As seen in Figure 43, the largest proportion of respondents were workers - of whom the largest group were workers from DHS (n = 78, 29% of all respondents). The next largest group of workers came from Community Service Organisations (n = 61, 22%). Most of the workers from DHS were Child Protection workers, with the next largest group being workers form the Secure Welfare Service. It was encouraging that 21 teachers (8%) responded to the survey.

The surveys received regarded children from all Take Two teams. Between 3 and 56 surveys were received from each team (M = 5.6; SD = 3.0). At least one survey came from a child giving feedback on each regional team and the Aboriginal team. The stakeholder surveys provided feedback from parents for six of the nine regional teams and from carers and workers for all regional teams. The stakeholder surveys from teachers provided feedback on four teams; two metropolitan and two rural teams.

Overall 104 (38%) of the surveys provided feedback on rural teams, 148 (54%) gave feedback on metropolitan teams and 22 (8%) gave feedback on a statewide team (Secure Welfare or the Aboriginal team).

Only two teams, both rural, recorded the numbers of surveys distributed from which the response rates for those teams could be calculated. The response rate for one team was 42 percent and 81 percent for the other. The average response rate for the two teams is 60 percent; however, the large variation between the two teams and their small sample size means it is not possible to estimate a meaningful response rate across the program.

10.3 Demographic data about the children and young people
Sixty percent of the stakeholder surveys related to children who were male (n = 156). The age of the children ranged from two to 18 years, with a mean age of ten years and eleven months (SD = 3.6). Nine percent (n = 24) were under 6 years, 42 percent were aged between 6 and 12 years (n = 112) and almost half (49%) were aged 12 years or older (n = 132). The age and gender of children who were the subject of the stakeholder surveys were generally representative of the overall Take Two client group.

The stakeholder surveys related to the experience of children involved in Take Two for an average of 1.2 years (SD = 5.9; range = 2.4 months to 2.5 years). Two thirds had been clients of Take Two for at least a year.

The majority of the 28 surveys completed by the young people themselves were completed by those aged 12 years or more (n = 16, 54%) with 44 percent aged less than 12 years (n = 12). The age range was 6 to 17 years.
In addition to the stakeholder feedback about the Aboriginal team, stakeholder surveys were received relating to Aboriginal clients from all but one metropolitan and one rural team. Overall, 14 percent of surveys (n = 33) related to the experience of Aboriginal children. The majority of these surveys were from workers (64%), followed by parents (15%), carers (12%) and children (9%).

10.4 Stakeholders’ experiences with Take Two

The stakeholder survey included five items about their experience with Take Two. It began by asking for an overall rating of the Take Two service following by four items that asked respondents to indicate their level of agreement with specific aspects of the service. These items were used as measures of satisfaction. Responses were analysed for all respondents and by respondent type: children; carers; workers; and parents.

The first item asked “How would you grade the service received from Take Two?” It had a different layout to other items. This may account for the large amount of missing data (36%) for this item which requires caution in the interpretation of responses and limits analysis.

As shown in Figure 44, 87 percent of those who responded to the item rated the Take Two service as excellent or good. Seven percent rated it as fair and six percent as poor. There was no difference in the overall rating of the quality of service among children, parents and carers, with 81, 80 and 80 percent respectively reporting that the service was excellent or good. Ninety percent of workers rated the Take Two service as excellent or good. There was no significant difference among workers from Child Protection, Community Service Organisations or teachers.

Table 39 provides an overview of the responses to four items related to satisfaction with the service. A large majority of stakeholders surveyed agreed or strongly agreed that: the people at Take Two were understanding (92%); they liked the service (91%); and the child’s culture, religion and/or spiritual beliefs were respected (91%). More than three quarters (77%) also agreed or strongly agreed that Take Two had helped the child with their life although nearly one in five respondents (18%) were undecided about this.

<table>
<thead>
<tr>
<th>Items in stakeholder survey</th>
<th>Strongly agree/agree</th>
<th>Undecided</th>
<th>Strongly disagree/disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I liked the service received from Take Two</td>
<td>246 91.4</td>
<td>11 4.1</td>
<td>12 4.5</td>
</tr>
<tr>
<td>I found the people at Take Two understanding</td>
<td>249 92.2</td>
<td>12 4.4</td>
<td>9 3.3</td>
</tr>
<tr>
<td>Take Two helped the child/young person with their life</td>
<td>206 77.2</td>
<td>49 18.4</td>
<td>12 4.5</td>
</tr>
<tr>
<td>Take Two respected the child/young person’s culture/religion/spiritual beliefs</td>
<td>235 90.7</td>
<td>24 9.3</td>
<td>0 0</td>
</tr>
</tbody>
</table>
All surveys completed that gave feedback on the experience of Aboriginal children strongly agreed or agreed that Take Two respected the child's culture, religion or spiritual beliefs compared with 90 percent for non-Aboriginal children. This difference was significant \( (X^2(2) = 7.70, p < .05) \). However, this difference was due to ten percent of respondents about non-Aboriginal children who were undecided. No respondent disagreed that Take Two respected the child’s culture, religion or spiritual beliefs.

One of the seven surveys where English was a second language for the child was undecided about this aspect of the Take Two service but the rest agreed or strongly agreed that it was respectful (86%). The larger proportion of undecided responses for this question may be affected by the combination of culture, religion and spiritual beliefs in one question and the general confusion that can occur about these issues separately and collectively. For example, at least two respondents responded that this item was not applicable. In the future this question will focus solely on the child's culture.

The four satisfaction items were also analysed according to the type of respondent. Eighty-nine percent of both children and parents agreed that "I liked the help Take Two gave me." An even greater percentage of carers (94%) and workers (91%) agreed with the similar statement, "I liked the service received from Take Two." There was no significant difference amongst the different type of workers for this item.

As shown in Figure 45, children, carers and workers all highly rated the people at Take Two in terms of understanding, with 93, 92 and 93 percent respectively agreeing. There was no significant difference between the different categories of workers. Slightly fewer parents agreed (86%), but this was not significantly different to the other respondent types.

There was variation in response to the item asking whether Take Two helped the child with their life by the type of respondent. As shown in Table 39, 77 percent agreed that Take Two had helped the child with their life. This includes 83 percent of workers. There was no significant difference between workers from Child Protection, Community Service Organisations or teachers. The responses of children and carers were the same with 74 percent of both groups agreeing that Take Two had helped. However, fewer parents (55%) agreed that Take Two had helped their child with their life. Importantly there was a larger percentage of parents who were undecided (35%) compared with other respondents and only ten percent of parents disagreed that the service had helped their child.

Nearly all carers (96%) and workers (94%) agreed that Take Two respected the child’s culture or religion, with no significant difference amongst the workers. Eighty-three percent of parents and 71 percent of children agreed. These lower figures among parents and children were due to the higher percentage of undecided responses: 17 percent of parents and 29 percent of children were undecided. Among all respondent types no respondent disagreed. There was a significant difference in responses to this item according to the type of respondent \( (X^2(3) = 18.20, p < .001) \).

There is a significant association between the length of time a child had been involved with Take Two and a respondent’s belief that Take Two helped the child with their life \( (r = -.251, p < .001) \). As Figure 46 shows when the child had been referred less than six months previously, 60 percent of responses agreed that Take Two helped the child with their life. This increased to 67 percent when a child had been in the service between 6 and 12 months, and to 85 percent when children had been with the service for a year or more.
The level of satisfaction of stakeholders’ experience with Take Two was calculated from the mean score of the four satisfaction items. Respondents with more than one missing response were excluded from the analysis.

The mean score for overall level of satisfaction with Take Two could range from one, for maximum satisfaction, to four, with less than 2.5 indicating a positive response. When excluding those who reported that they were undecided, 96 percent of survey respondents had a mean score of two or less with an overall mean of 1.4 (SD = 0.47), indicating overall satisfaction with the Take Two service.

The mean score responses to these four questions was 1.5 (SD = 0.49), with 92 percent of children having a mean score of two or less. The results were similar for parents (96% M of 2 or less, overall M = 1.4, SD = 0.47), and workers (94% M of 2 or less, overall M = 1.4, SD = 0.49). All carers had a mean of two or less, with an overall mean of 1.6 (SD = 0.40) indicating satisfaction of their experience with Take Two.

### 10.5 Perception of outcomes for Take Two clients

Stakeholders were asked about their perception of outcomes for the children involved with Take Two. These six items required fixed-choice responses. These items were not included in the Secure Welfare survey. As discussed later, it is important to distinguish between perceptions of outcomes and levels of satisfaction.

Table 40 provides an overview of the number of respondents who agreed, disagreed or were undecided about each of the six items relating to perceptions of outcomes for the child. In all items a majority of respondents agreed that there had been an improvement. Sixty percent of respondents thought the young person was better able to cope when things go wrong and three quarters of the children who responded to the survey reported being happier.
More children and workers agreed that there had been a positive change than parents or carers, although these differences were not significant. A smaller proportion of parents indicated change in all items compared with other stakeholders except for changes within the family, where fewer carers agreed than parents. A greater percentage of Child Protection workers (68%) and teachers (67%) agreed or strongly agreed that the child was doing better at school compared with carers (62%) and workers from Community Service Organisations (53%).

There was no significant difference for any item in relation to age, gender or Aboriginal identity. The relationship between length of involvement and perceptions of outcomes is shown in Figures 47 and 48. None are statistically significant; however, a trend to greater perception of positive change with longer Take Two involvement was apparent.

Table 40
Responses to Stakeholder Survey relating to Perception of Outcomes for the Child

<table>
<thead>
<tr>
<th>Items in stakeholder survey</th>
<th>Strongly agree /agree</th>
<th>Undecided</th>
<th>Strongly disagree /disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The child/young person’s problems are better since Take Two became involved</td>
<td>167 68.2</td>
<td>50 20.4</td>
<td>28 11.4</td>
</tr>
<tr>
<td>The child/young person is better at handling daily life (not on client version)</td>
<td>152 69.1</td>
<td>49 22.3</td>
<td>19 8.6</td>
</tr>
<tr>
<td>I am happier (only on client version)</td>
<td>21 75.0</td>
<td>5 17.9</td>
<td>2 7.1</td>
</tr>
<tr>
<td>The child/young person gets along better with family members</td>
<td>152 61.8</td>
<td>68 27.6</td>
<td>26 10.6</td>
</tr>
<tr>
<td>The child/young person gets along better with friends and other people</td>
<td>153 62.2</td>
<td>65 26.4</td>
<td>28 11.4</td>
</tr>
<tr>
<td>The child/young person is doing better in school and/or at work</td>
<td>150 62.0</td>
<td>59 24.4</td>
<td>33 13.6</td>
</tr>
<tr>
<td>The child/young person is better able to cope when things go wrong</td>
<td>149 60.1</td>
<td>64 25.8</td>
<td>35 14.1</td>
</tr>
</tbody>
</table>

| The child/young person’s problems are better since Take Two became involved | N 167 | % 68.2 | /agree  |
| The child/young person is better at handling daily life (not on client version) | N 152 | % 69.1 | /agree  |
| I am happier (only on client version) | N 21 | % 75.0 | /agree  |
| The child/young person gets along better with family members | N 152 | % 61.8 | /agree  |
| The child/young person gets along better with friends and other people | N 153 | % 62.2 | /agree  |
| The child/young person is doing better in school and/or at work | N 150 | % 62.0 | /agree  |
| The child/young person is better able to cope when things go wrong | N 149 | % 60.1 | /agree  |

Figure 47: Percentage of responses to ‘The child gets along better with family members’ by length of Take Two involvement (N=199)
Responses to the question on the child's version of the survey asking whether they agreed or disagreed with the statement 'I am happier' did not follow this trend. There was 100 percent agreement among children involved with Take Two for between 6 and 12 months and then a reduction after that, although it remained higher than those in the initial six months of involvement. However, as there were only 19 respondents it was not possible to analyse further.

The possible mean score for overall perception of outcomes was calculated based on these six items, with a possible range from one to four, with less than 2.5 indicating a positive response. When excluding those who reported that they were undecided, 82 percent of survey respondents had a mean score of two or less with an overall mean of 1.8 (SD = 0.63) indicating positive gains since Take Two involvement. The children's averaged responses to these six questions was 1.7 (SD = 0.69), with 86 percent of children having a mean score of two or less. The results were similar for workers (86% M of 2 or less, overall M = 1.8, SD = 0.58). Among the different categories of workers, there was a high level of agreement regarding positive change having occurred:

- Teachers (88% M of 2 or less, overall M = 1.8, SD = 0.56);
- Child Protection (90% M of 2 or less, overall M = 1.8, SD = 0.47); and
- Community Service Organisations (81% M of 2 or less, overall M = 1.9, SD = 0.67).

For one survey completed by a Community Service Organisation worker there was a mean score of four indicating that this worker strongly disagreed with each of the six items relating to outcomes about the child.

Seventy-three percent of carers had a mean of two or less, with an overall mean of 2.0 (SD = 0.71) and among parents 68 percent had a mean of two or less (overall M = 2.1, SD = 0.62). In other words more than two thirds of carers and parents, on average, agreed that improvement had occurred.

10.5.1 Comparing satisfaction with outcome

Perceptions of whether or not certain aspects of the children's situation have improved are different than asking about their experience of the program. For example, studies by Brunk and Ferris (2003) found a higher level of satisfaction regarding how families experienced the service (81%) than their perception of outcomes (56%), but the more satisfied the more likely a positive outcome was to occur.

Brunk, Innes, and Koch (2003) found that caregiver perceptions of the child mental health services were strongly and positively associated with perceived improvements in the children's behaviours and functioning. There were large correlations between a number of the items in the survey, including those items exploring satisfaction correlated with those exploring perception of outcomes.

Most item correlations in relation to the respondent liking the help Take Two provided ranged from moderate to very large (e.g. child getting along better with friends: \( r = .34, p < .001 \); the child coping better when things go wrong: \( r = .40, p < .001 \); Take Two helping the child with their life: \( r = .53, p < .001 \); and Take Two staff being understanding: \( r = .72, p < .001 \)).

The item about Take Two's respect for culture or spiritual beliefs was moderately to largely correlated with many other items, such as finding Take Two staff understanding (\( r = .43, p < .001 \)), the child doing better at school (\( r = .48, p < .001 \)) the child getting along better with their family (\( r = .64, p < .001 \)), the child being better able to handle daily life (\( r = .67, p < .001 \)), and Take Two helping the child with their life (\( r = .76, p < .001 \)).

Most of the remaining items in relation to satisfaction with the service and opinions regarding outcomes and positive change for the child showed moderate correlations. Overall, there was a moderate correlation between the mean of the four items related to satisfaction with the mean of the six items related to outcomes (\( r = .58, p < .001 \)).
10.6 Perception of outcomes of Take Two Secure Welfare

Due to differences in the content of the surveys, further analysis of the Secure Welfare surveys was conducted separately. The different items on the Secure Welfare survey reflected more of the brief nature of the Take Two role within the Secure Welfare Service and the focus on assessment and recommendations.

Of the 19 Secure Welfare surveys, nine (47%) were completed by staff of the Secure Welfare Service, six (32%) by Child Protection workers, and four (21%) by Community Service Organisation workers. They were asked to complete the survey regarding a young person they knew who had involvement with Take Two within the Secure Welfare Service. Of these 19 surveys, 71 percent were in relation to young women, which reflect the greater number of females in the Secure Welfare Service. Four of the young people were Aboriginal (27%) which is higher than the general over-representation of Aboriginal children. The young people ranged in age from 13 to 17 years with a mean age of 15.2 years.

The most striking finding among the surveys was that there were no responses to any of the items that disagreed with either satisfaction with the service or regarding a particular process, such as assessments and recommendations. The item regarding how respondents grade the overall service received from Take Two was re-positioned in this version of the survey, which may have contributed to the 100 percent response rate to this item. Ninety-five percent of respondents rated the service as excellent or good. Table 41 shows a summary of the results from this survey in relation to the Take Two role within the Secure Welfare Service.

<table>
<thead>
<tr>
<th>Items on Secure Welfare survey</th>
<th>Strongly agree /agree</th>
<th>Undecided</th>
<th>Strongly disagree /disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I liked the service received from Take Two</td>
<td>18</td>
<td>94.7</td>
<td>1</td>
</tr>
<tr>
<td>Take Two helped the young person with their life</td>
<td>16</td>
<td>84.2</td>
<td>3</td>
</tr>
<tr>
<td>Take Two respected the young person's culture</td>
<td>16</td>
<td>94.1</td>
<td>1</td>
</tr>
<tr>
<td>Take Two staff spoke with the young person in a way he/she understood</td>
<td>19</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>I received the information I needed about the Take Two assessment and recommendations</td>
<td>18</td>
<td>94.7</td>
<td>1</td>
</tr>
<tr>
<td>The young person was sufficiently informed of the Take Two assessment and recommendations</td>
<td>13</td>
<td>81.3</td>
<td>3</td>
</tr>
<tr>
<td>I found the assessment that Take Two provided contributed to my understanding of this young person</td>
<td>17</td>
<td>94.4</td>
<td>1</td>
</tr>
<tr>
<td>Take Two's recommendations were practical and realistic</td>
<td>17</td>
<td>94.4</td>
<td>1</td>
</tr>
<tr>
<td>I have implemented most of the recommendations</td>
<td>14</td>
<td>87.5</td>
<td>2</td>
</tr>
</tbody>
</table>

Examples of reasons provided for why some recommendations were not implemented included the unavailability or waiting lists for services, the young person’s unwillingness to engage and the young person’s instability.

An obvious limitation in this survey process was the inability to ask young people in the Secure Welfare Service themselves to provide feedback. This was due to the delay in the implementation of the methodology and the view that it was not appropriate to ask them retrospectively. This will be redressed in the subsequent evaluation.

10.7 Comments from the surveys

The surveys had two open-ended questions regarding what has been the most helpful thing about the services received from Take Two and what would improve the service. There was also a question for any other comments on the surveys other than the Secure Welfare surveys. This change was based on early analysis of how that question was being completed by the other respondents.

10.7.1 What was helpful?

The children’s views:

When responding to the open-ended question of what was helpful about Take Two the children provided a range of responses. Table 42 provides a summary of their responses and shows that most frequently this question was answered about the individual Take Two worker who was the face of Take Two to the children.
Examples of comments regarding what they found helpful about Take Two in the children’s own words are presented below. The most frequently mentioned helpful elements were talking and being helped with problems. The children appeared to focus on the importance of communication with them.

### Table 42
**Responses from Children regarding what was Helpful about Take Two**

<table>
<thead>
<tr>
<th>What was helpful about Take Two?</th>
<th>N of times mentioned by children/young people</th>
<th>% by number of surveys completed by children/young people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talking</td>
<td>6</td>
<td>26.1</td>
</tr>
<tr>
<td>Being helped with problems</td>
<td>6</td>
<td>26.1</td>
</tr>
<tr>
<td>Fun and games</td>
<td>3</td>
<td>13.0</td>
</tr>
<tr>
<td>Relationship with clinician</td>
<td>2</td>
<td>8.7</td>
</tr>
<tr>
<td>Everything</td>
<td>1</td>
<td>4.3</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2</td>
<td>8.7</td>
</tr>
<tr>
<td>Nothing</td>
<td>3</td>
<td>13.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23</strong></td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td>No response</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

**The parents’ views:**
Seventeen parents (59%) had one or more statements regarding what they found helpful. The major theme was the direct support they received from Take Two, as mentioned by 35 percent of the parents. One-off comments focused on the availability of the Take Two worker, their knowledge and understanding of the child and the family and the expertise of the workers. The following are some of the comments from parents.

### What helped? - according to children

- “Just being able to talk when I have needed to.” - age 16
- “Getting to know [her], and talking about my problems!” - age 12
- “Talking with [him] because he is the best friend I ever had to talk with.” - age 11
- “[She] has talked to me about my life and how to get along with people and the death of my mum.” - age 11
- “That you helped me with my BIG problems. Like my anger.” - age 7
- “Take two has been most helpful with my Depression & stuff like that.” - age 13
- “They teach me a lot and I have fun playing games with [Clinician’s name]. Thank Take Two.” - age 11
- “He brings me cakes and supports me.” - age 16
- “Them learning more about my life.” - age unknown
- “Nothing yet because it’s been an assessment.” - age 11

### What helped? - according to parents

- “Making me be the Parent. Feeling good within myself.” - Mother
- “The holistic approach - with each family member able to meet individually with one of the team, plus the family therapy.” - Mother
- “I like the one-on-one approach.” - Father
- “They helped [my child] understand more about some things like [her brother] and every day life.” - Mother
- “An understanding of the problems facing my child.” - Father
- “The way they approached and understood the family.” - Mother and Father
- “The most helpful thing about the service is supporting the child having contact with both mother and with other appropriate child services, such as school.” - Mother
- “Patient, understanding, available, lots of things.” - Mother
In relation to the 19 surveys received from workers involved directly or indirectly with Take Two within the Secure Welfare Service, 17 (90%) commented on the usefulness of the assessment, consultations, feedback and advice, providing a clearer understanding of how to work with the child and the recommendations provided.

Following are some quotes by workers from a range of settings and relationships with the children.

**The workers’ views:**

One hundred and fifteen workers (69%) made at least one statement of what they found helpful about Take Two. Similarly to parents, the major theme arising from the 50 carers’ surveys were the 20 percent who commented on the direct support received from Take Two to the carer. The next most frequent theme was the 14 percent who commented favourably on the knowledge and level of understanding of the Take Two clinicians. The child receiving therapy was noted by 12 percent and the child’s relationship with the Take Two clinician (8%) was also listed.

The following are some quotes from foster parents, kinship carers (primarily grandmothers) and residential care staff.

**What helped? - according to carers**

“*To be able to speak to someone when a problem arises*”

“The support received when each difficult problem arises.”

“Just having someone to talk to about everything.”

“Finding out more about our foster child and why he has behavioural problems, so that we in turn know the best way to help him.”

“Take Two has given guidelines that are used on a daily basis.”

“Different ways to approach each behavioural problem and the confidence given to us that we can do this.”

“Being able to talk to the worker and finding the child enjoys seeing the worker.”

“Intensive therapy.”

“A place where he can get rid of his anger and try to understand his emotion.”

“Having an experienced person to help/advise.”

“Knowing he has someone to help him with his problems.”

“The worker obviously cared about the young person and was committed to improvements.”

“Good communication and helpful with support and ideas.”

**What helped? - according to workers**

“Good communication and follow-up.” - CAMHS Worker

“I found the feedback great. Certain suggestions/tips were helpful.” - Aboriginal Service Worker

“Regular appointments, care team meetings and availability for consultation.” - Residential Care Case Manager

“Our worker was fantastic at giving us information that helped us in gaining a greater understanding of the child.” - Teacher

“Clinician’s level of expertise.” - Child Protection Worker

“Constructive suggestions as to how DHS can support the child’s situation.” - Permanent Care Worker

“Advocacy and support in relation to critical incidents, DHS issues and relationships with relatives and carers.” - CSO Case Manager

“The assistance offered not only with the client but also with his mother and sister.” - DHS Case Contracting

“The ability to work constructively with the care team and within the case plan.” - CSO Case Manager

“Responsive. Practical. Empathic.” - Worker, unspecified

“The ability to engage and maintain a long term relationship.” - DHS Worker

“Child anticipates and looks forward to visits.” - Permanent Care Worker

“Quick assessment process followed up by actual therapy for the child on a regular basis, so far.” - Foster Care Worker

“Take Two has been a service that has been willing to work with my client.” - CSO Case Worker

“Clinicin worked with the child at their pace and had a respectful manner.” - Child Protection Worker

“The outreach to visit the child at school [and] the parents home.” - Child Protection Worker

“Every aspect of the service has been helpful.” - CSO Case Manager

“A clearer understanding as to the young woman’s behaviour and on how to improve on working with the young person” - Secure Welfare Service worker

Frederico, Jackson, & Black (2006) "Give Sorrow Words" - Take Two Second Evaluation Report 2004-2005, La Trobe University, Bundoora, Australia
10.7.2 What could be improved?

The children’s views:

Twenty-three of the 28 children who completed a survey wrote a response to the question about how Take Two could improve the service. As shown in Table 43, 13 children commented that no improvement was necessary. A quarter of the children made suggestions of improvements including a request for more direct help, more activities and more help for the family.

Table 43
Responses from Children regarding what could be Improved about Take Two

<table>
<thead>
<tr>
<th>What could Take Two improve?</th>
<th>N of times mentioned by children</th>
<th>% by number of surveys completed by children</th>
</tr>
</thead>
<tbody>
<tr>
<td>More help for self</td>
<td>3</td>
<td>13.0</td>
</tr>
<tr>
<td>More activities and sessions</td>
<td>3</td>
<td>13.0</td>
</tr>
<tr>
<td>More help for family</td>
<td>1</td>
<td>4.3</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>13.0</td>
</tr>
<tr>
<td>I don’t know</td>
<td>4</td>
<td>17.4</td>
</tr>
<tr>
<td>Nothing/not much</td>
<td>7</td>
<td>30.4</td>
</tr>
<tr>
<td>Don’t need improvement</td>
<td>2</td>
<td>8.7</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>100</td>
</tr>
<tr>
<td>No response</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

The following quotes are from children about how Take Two could be improved. Their responses related to concrete activities and reflected the role of others in their social world.

What could be improved? - according to children

"Bring food." - age 13
"Fun things for teenagers to do." - age unknown
"I don’t know but I don’t think they do anything to help.” - age 13
"I Like [her to ] help me more in my life" - age 17
"More sessions in here and outside.” - age 16
"More things to do." - age 11
"Them helping me with my family problems." - age 12
"More communication with my schooling.” - age 12
"Help mum become a better mum." - age 12
"To B like a real person & 4 the workers to “chill out”" - age 16
"Well I would say they don’t need any improvement, they have been great and very helpful.” - age 16
"You come to our house with your things with you.” - age 7
"Your to good you don’t need to be improved. Bye bye.” - age 10

The parents’ views:

Parents had slightly fewer comments regarding what could be improved (52%) compared to what they found helpful (59%). The most frequent comment made by 27 percent of the parents was in providing a more practical approach or working directly with the family or more work with the child. A couple of parents also commented on the need for more feedback to families about what is happening with their child from Take Two’s perspective. A couple of other parents expressed concern at the delay in getting into the program or that Take Two should stay involved with their child for longer. The following are examples of parents’ comments in their own words.

What could be improved? - according to parents

“Do more direct work with the children.” - Mother
“More family work.” - Mother
“Nothing I can think of - they were great people.” - Mother and Father
“If Take two services had homes for behavioural challenged children, under the supervision of Take Two workers because they seem to care.” - Mother
“Should be seen at home sometimes.” - Mother
“That they make a more determined effort to contact and communicate with separated father.” - Father
“Take Two counsellors should be able to intervene when a child requires counselling and not wait for the child to elect to participate.” - Mother
“Longer involvement.” - Mother
The carers’ views:
Whereas nearly 90 percent of carers had at least one comment regarding how Take Two was helpful, just over half (52%) had a comment regarding what could improve the service. Themes arising from carers regarding what could be improved had some similarities and some differences with parents. The most frequent theme for carers was improved communication and feedback to the carers (18%); broader systemic change beyond Take Two’s role (10%) and practical assistance to the carers (10%). Other themes included comments that there was insufficient service available to meet the demand. A couple of comments expressed concern regarding the worker’s approach, such as Take Two needing to be more focused on working with the parents and to leave the child’s issues to the carer. The following are some of these and other comments in the carers’ own words.

What could be improved? - according to carers
“Earlier intervention for the support of the child’s needs.”
“It looks as though team members are not talking to one another - conflicting advice.”
“Not having to wait so long to get onto the program.”
“More detailed and frequent feedback.”
“To have a shorter waiting list for Take Two.”
“More information about what happened during child session - therefore better understanding to be able to deal with child’s behaviour following sessions.”
“Following through with what they say i.e. calling when they say they will.”
“We can’t think of anything! It was great for us.”
“More contact and more involvement with children if possible.”
“Assisting the carer with support and someone to talk to.”
“Being able to utilise the service until children’s needs are met, and not cut off because of arbitrary dates e.g. 3-6 months following permanent care order.”

The workers’ views:
Over half (57%) of the workers had at least one suggestion regarding what could be improved. The most common theme was the insufficient capacity of the service to meet the demand (11%). An associated theme was the lack of availability of the service (9%). Seven percent commented on the need for broader changes within the overall system and another seven percent made suggestions regarding how Take Two might work differently with the children and their networks. There were a small number of comments regarding some individual worker attitudes and the need for improved communication and feedback processes.

In relation to the Take Two role within the Secure Welfare Service, there were 11 surveys (65%) with one or more comments regarding what could be improved. Nine of these commented on the need for more staff or funding for the service. One-off comments included more communication regarding the Take Two clinician’s role, an easier referral process, after-hours availability, regional Take Two teams to have greater capacity to work with adolescents, training and information sessions and better integration into case planning processes.

The following are examples of quotes from various workers illustrating these and other themes.

What could be improved? - according to workers
“Further outreach.” - Home Based Care Worker
“More clinicians - they do excellent work.” - CAMHS Worker
“Making sure that contact with the young person is weekly, as when appointments were missed the young person’s behaviour escalated.” - CSO Case Worker
“Referral process is tedious, complicated and too slow.” - Child Protection Worker
“Young people have been involved in decision making, takes too long, left hand doesn’t know what the right hand is doing - this leads to confusion and bad behaviour.” - Teacher
“If only all children could access your service.” - Teacher
“It seems the clients who do things more seem to get the service - rather than the clients what are just as troubled but more quiet.” - Residential Care Worker
“Take Two service to move into resi unit.” - CSO Case Manager
“During my involvement with several Take 2 Workers, especially during case plan meetings, there seems to be a culture of ‘self importance’…[they] seem to think their advice and involvement is the most important in the child’s life.” - Home Based Care Worker
“Staff to work alongside DHS and not have a ‘them and us’ attitude, that was presented to the client’s family.” - Child Protection Worker
“Increased service capacity - more staff to respond to more clients.” - Child Protection Worker
“For it to be accessible for all young people coming into care, as it assists.” - CSO Case Worker
“If Take Two concentrated on their own work and let other services go about their business.” - Child Protection Worker
“Increased participation with court processes.” - DHS Case Contracting Worker
“More workers to cope with the high demand of clients” - Secure Welfare Worker
10.7.3 Focus Group Regarding Take Two within the Secure Welfare Service

The focus group undertaken with staff of the Secure Welfare Service provided an opportunity in addition to the stakeholder surveys to elicit comments regarding the nature of Take Two’s role and its interface with the Secure Welfare Service, both as a service system and in terms of the client group.

This process emphasised that the role of Take Two in the Secure Welfare Service is highly valued by the Secure Welfare Service staff. Words and phrases used to describe the Take Two contribution within the Secure Welfare Service included:

- ‘priceless’,
- ‘so beneficial’,
- ‘part of the team’,
- ‘expertise’,
- ‘availability’,
- ‘useful’,
- ‘practical recommendations’,
- ‘affirming of the skills and knowledge of staff’,
- ‘contextualising what we do’.

In making their comments the staff acknowledged some difficulty in analysing the role of Take Two separately from the individual Senior Clinician, who has been in the role since the commencement of the service, and from members of the Take Two Aboriginal team.

Themes arising from the focus group discussion included:

- The importance of the Take Two program being an established part of the Secure Welfare Service thus enabling the Take Two Senior Clinician to be a member of the Secure Welfare Service team.
- Take Two building capacity in the Secure Welfare Service by addressing the emotional and psychosocial needs of the young people particularly through psychological assessments, recommendations for case planning and identification of strategies to guide work with the young people.
- The interface between Take Two and CAMHS role within the Secure Welfare Service.
- A strong theme emerging was the role of the Take Two Secure Welfare Senior Clinician in building capability amongst the staff of the Secure Welfare Service through contributing to a better understanding of the needs of the young people. This enabled the Secure Welfare Service staff to affirm their own skills, build upon these and thus increase their confidence and effectiveness in their work with young people.

The Take Two program was identified as an integral part of the Secure Welfare Service providing expert input as did the services of the Alcohol and Other Drugs Nurses employed through the Youth Outreach Team at DASWest, educational services provided by Baltara and medical services provided by an adolescent-focused general practitioner. The Secure Welfare Service staff stated that having expertise in these areas as part of the Secure Welfare Service built capability in response to the needs of the young people. It was commented that the value of the contribution of these specialist services was more than the technical input. It was the fact that the personnel ‘merged’ with the Secure Welfare Service team and were part of the team response to the young person.

When asked what specifically Take Two provided to the Secure Welfare Service, participants stated that there is a ‘greater understanding of the child and risk assessments’ for ‘all our children’ and this was ‘priceless’ as it facilitates a greater understanding of these children and the ‘immediate needs of the child’. This information enabled more informed and faster decisions being made for the young person. This was identified as an important element for the Secure Welfare Service as staff need to know quickly what these issues are and how to work with the young person who will only be with the service for a short time. It was stated that it felt like 95 percent of the young people in the Secure Welfare Service were referred to Take Two Secure Welfare (actually 42 percent of the Secure Welfare Service clients were Take Two clients over 2004 and 2005). It was thought that only the ‘quiet ones’ or those who had other specialist professionals or were clients of regional Take Two were not referred. However, it was thought that the Take Two service could be utilised by all clients of the Secure Welfare Service.

The role of Take Two in providing direct service to clients in the Secure Welfare Service through psychological assessments was valued particularly as they were able to inform the case planning meeting which occurs within 48 hours of the young person’s admission. Participants commented that most young people referred to Take Two within the Secure Welfare Service wanted to meet with the Take Two Senior Clinician and they felt this was in part because the Senior Clinician spoke openly with the young people.

The Secure Welfare Service staff were appreciative that the Take Two Senior Clinician wrote clear assessment reports which were useful in guiding immediate work with the young people during their stay in the Secure Welfare Service and contributed to ongoing case plans for the young person. Risk assessments of highly vulnerable young people were identified as a major contribution.

Some Secure Welfare Service staff said they were unclear of the differences between the role of Take Two and CAMHS. However, others understood the CAMHS focus on mental health and indicated the two programs worked collaboratively for the young person. All staff were clear that if the young person was a client of CAMHS at the time of admission to the Secure Welfare Service that it would be unlikely they would engage Take Two for an assessment. However, the Take Two Senior Clinician was seen to provide generic advice as to the management and intervention with these young people whilst they were in the Secure Welfare Service. It was also suggested that the relationship with CAMHS services had improved as the Take Two Senior Clinician could clarify the role of CAMHS and avoid unrealistic expectations of that service. It was appreciated that the Take Two service liaised with CAMHS and Protective Adolescent Teams and used shared language to discuss the needs of the young people.

The staff valued the Take Two Senior Clinician’s availability to spend time with young people and staff during the day-
to-day activities of the units and this involvement was seen to contribute to the work of the Secure Welfare Service. It was also commented that the Senior Clinician knew Secure Welfare Service staff well and thus could suggest who might be an appropriate person to undertake a particular activity with a young person. A number of participants commented that having a Senior Clinician who could engage in the day-to-day operations of the service was more valuable than an external person who did not have the oversight of the entire service. Moreover, staff could observe how the Senior Clinician responded to the young people.

The accessibility of the Senior Clinician to the staff of the Secure Welfare Service is a highly valued feature of the Take Two role in this context. Knowing the Take Two role was available was recognised as supportive. Secure Welfare Service staff appreciated the willingness of Take Two in the Secure Welfare Service to accept referrals - at times not requiring detailed documentation immediately. It was commented that the Secure Welfare Service appeared to be used as a fast track to Take Two assessment when the regional Take Two was perceived as being unable to see more clients. In addition, there was some suggestion that the role of Take Two extended beyond direct work with young people in the Secure Welfare Service, such as providing follow-up consultations after a young person had been discharged.

Specific comment was made of the role of the Take Two Aboriginal team in the Secure Welfare Service. Staff were appreciative of the expert knowledge provided by the team. The value of the team to the young people was commented upon and it was noted how young people change when they realise they either know the Aboriginal clinician or he knows their family. It was suggested that the Secure Welfare Service needed greater access to the Aboriginal clinicians than they were able to access due to the limited availability of the team.

In addition to Take Two’s direct role with the young people and the Secure Welfare Service as a whole, participants identified that the Take Two Senior Clinician was able to make recommendations for carers and the young person’s ongoing case plan. They were aware that the Senior Clinician would engage with carers and others in the service system surrounding the young person to facilitate a more effective response to the young person and be an advocate for the young person. This was frequently done through the assessment reports and recommendations written by the Senior Clinician.

Some Secure Welfare Service staff had a limited understanding of the role of Regional Take Two teams with some staff perceiving that these teams were focused on younger children. This perception was corrected by other Secure Welfare Service staff who had greater contact with Take Two and who had a clearer understanding of the regional service.

In summary, staff of the Secure Welfare Service expected the Take Two Secure Welfare staff to enhance the service’s ability to provide a high quality service to young people and to fill a gap of providing assessments of young people in crisis. This expectation was seen to be well and truly met. Recommendations for change in the Take Two service were a request for more resources, such as additional Take Two staff located within the Secure Welfare Service. Greater access to the Take Two Aboriginal team was also stated as a need and the value of the involvement of the Aboriginal clinicians was noted. All focus group participants were full of praise of the work of the current Take Two Senior Clinician who has shaped the role of Take Two in the Secure Welfare Service and added great value to the service.

10.8 Summary

The comments from the stakeholder surveys and the focus group, along with the quantitative results, provide a rich source of information that informs program development, practice and the evaluation. This has also been a useful process in trialling the surveys themselves leading to further adaptation.

This chapter has reported on both satisfaction levels with the service and perception of outcomes of the service for the child. These are distinct but related concepts that are important for services to hear and respond accordingly. The high degree of satisfaction across the respondents is encouraging, but also highlights work required, especially with parents. The more outcome specific questions were also predominantly positive, although not as high as levels of satisfaction. This same finding has been seen in other studies (e.g. Brunk, Innes, & Koch, 2003) and is consistent with the results from the outcome measures reported on in this evaluation. In other words, the results are indicating that positive outcomes are occurring for many, but not all, children and that the work involved should not focus on short-term gains, but meaningful and lasting changes.
Chapter 11: Outcomes - Take Two perspectives on outcomes and related factors

11.1 Overview

Take Two clinicians in every team, except Secure Welfare, were asked to complete surveys for all cases open during 2005 (n = 352). Almost all of the clinician surveys were completed in the second quarter of 2006. The response rate was 100 percent, although some surveys had missing data when information was unknown, such as in a small number of cases where the case had closed and the survey was completed by someone other than the primary Take Two clinician.

The survey asked clinicians to rate client outcome or change in a number of areas with a focus on the child, his or her family, carers, school and the system supporting them. The survey sought data on the characteristics of the client interventions utilised (data reported in Chapter 5) and the clinician’s assessment of the outcome or current situation of the child.

11.2 Demographic information regarding children who were clients of Take Two in 2005 (not including Secure Welfare)

Due to the 100 percent response rate, the demographic information regarding the children who were the subject of these surveys reflects all open cases within Take Two during 2005 with the exception of Secure Welfare clients.

A summary of some of the characteristics of these children at the time of referral to Take Two includes:

- Mean age was 9.4 years (SD = 4.0) with a range of 4 months to 17 years.
- 64% were male.
- 63% were from metropolitan areas.
- 14% were Aboriginal.
- 20% were living with one or both parents; 19% were in kinship care; 39% were in some form of home-based care; and 18% were in residential care.
- Mean of 6.4 (SD = 5.7) previous placements at time of referral.
- 92% were on a court order at time of referral and 63 percent were on a Custody or Guardianship order.

Ninety children (26%) ceased involvement with Take Two during 2005 with another 63 (18%) ceasing involvement before the end of June 2006. The remaining cases either closed subsequently (n = 13; 4%) or were open at the time of this analysis (n = 186; 53%).

11.3 Trauma and stability of placement at time of referral according to Take Two clinician

Take Two clinicians were asked to describe the situation at the time of initial assessment in relation to the children’s trauma symptoms and the stability of their placement. Trauma presentation was described as active, complex or low, as described in Chapter 2. Stability of placement relates to the child’s access to a consistent, nurturing carer.

As shown in Figure 49, nearly three fifths of the sample was described as having high trauma or deprivation with low stability of placement (n = 199, 59%). Another one in eight were rated as having active trauma, but with more stable placements (n = 43, 13%). Sixty-four children had complex trauma presentations, but with stable placements (19%), while a smaller number (n = 23) had low trauma presentations, but low placement stability (7%). These children may present with behavioural difficulties that pose challenges for the carers but do not present with trauma symptoms.
These results indicate that most Take Two clients display considerable trauma symptoms, both chronic and acute. They may or may not have met the full criteria for Posttraumatic Stress Disorder, but were nonetheless traumatised. These children represent the core focus of Take Two. However, close to a third (31%) had either chronic or acute trauma presentations, but were in stable placements. There were no significant age or gender differences or difference between whether children lived in metropolitan or rural areas in terms of the clinicians’ perception of the children’s trauma presentation and stability of placement at the time of referral. There was a significant difference between Aboriginal and non-Aboriginal children ($\chi^2(4) = 21.43, p < .001$) with more Aboriginal children having the combination of high trauma or deprivation and low stability of placement compared with non-Aboriginal children.

### 11.4 Engagement with children

For the 302 (86%) children where clinicians considered the item applicable, Take Two effectively engaged with the majority of children (82%). There were 34 children (11%), however, who were not effectively engaged with the service, more than half of whom were still open cases at the time of analysis. In another six percent of cases, the clinicians were undecided regarding the level of engagement.

A significant difference was found between age and level of engagement ($F = 6.69, p < .001$), with younger children being more engaged than adolescents, although the majority of all age groups were engaged. There were no significant differences in engagement according to gender, rural versus metropolitan region, Aboriginal heritage or whether or not the case was subsequently closed. Despite not believing that they had effectively engaged with 34 children, Take Two clinicians rated over half of these 34 (58%) as having a good or fair overall progress and that problems had improved for nearly a third (32%) of them.

There were significant, albeit not large, positive correlations found between effective engagement and most of the other items in the survey. The largest correlations with engagement were how they rated improvement in the child’s overall progress ($r = .43, p < .001$) and the child’s problems having improved ($r = .35, p < .001$).

### 11.5 Overall client progress since Take Two involvement

Take Two clinicians responded about how they would grade the overall progress of the client since Take Two involvement. Clinicians rated the child’s overall progress as generally good/excellent (56%) or fair (34%). Progress was considered poor for a small proportion (10%) of children. The progress of thirty-five children was not rated as they were in the assessment phase (10%). The progress was not known or data was missing for 20 (6%) children, such as when the survey was completed by someone other than the primary clinician.

There were significant moderate to strong positive correlations found between the children’s overall progress with most other questions reflecting outcomes.

On average children aged between three and nine years were significantly more likely to show overall progress than other age groups ($F = 2.49, p < .05$). There was no significant difference in relation to children’s gender or whether they were Aboriginal. There was no significant relationship found between length of time Take Two was involved and client outcomes for the 168 closed cases. The average number of months closed cases were open for was 14.6 months (range = 1.4 to 31.9 months, $SD = 0.77$).

### 11.6 Child-related changes

Seven questions in the survey assessed client change. A combined mean score based on each of these items was calculated to give an indicator of the overall domain of client change. Four fifths ($n = 281$) of clients were included in this, with the rest omitted due to having three or more responses regarding client change which were not applicable or not known.

The possible mean score for overall client change for these 281 children ranged from one to four, with below 2.5 indicating the Take Two clinician’s perception of client-related improvement. The mean for client-related improvement was 1.9 ($SD = 0.59$), indicating positive change. For one child there was a mean of four, reflecting the clinician’s perception of a negative outcome for this child. This case was one where the Take Two clinician believed the service had not engaged effectively with the child.

The following analysis of individual questions illustrates the level of complexity of the child’s presentation and the multifaceted nature of improved outcome, where improvements can be seen in one domain such as school or family life, but not in another, such as problem resolution or capacity to handle everyday life.

### 11.6.1 Improvement in child’s problems

Clinicians rated over two thirds of children’s problems as having improved (71%). Again there was a proportion of children whose problems did not improve (14%) and clinicians were undecided whether improvement had occurred or not in a similar proportion of clients (15%). There were no significant differences in relation to age, gender, Aboriginal heritage and whether they lived in a metropolitan or rural area.

Improvements in problems were significantly related to other client outcome items indicating that improvement of the client’s problems was associated with other positive outcomes.
11.6.2 Child’s improved capacity to handle every day life

Two thirds (68%) of the children were considered to be able to manage everyday life in a better way since intervention with Take Two. Clinicians were undecided whether improvements had occurred for a substantial proportion of clients (21%) and a further 11 percent did not show improvement in this area. There was a significant difference between different age groups for this question ($F = 2.41, p < .05$), with children under the age of 12 years showing greater improvement. No other significant differences were found.

11.6.3 Child’s improved relationship with family members

Relationships with family members were rated as improved for just over half of the children (54%) and not improved for 18 percent. However, clinicians were undecided in relation to this question in 29 percent of the cases. There were no significant differences for age, gender, Aboriginal heritage and whether they lived in a metropolitan or rural area.

11.6.4 Child’s improved relationship with carers

Over two thirds of the sample (69%) were in out-of-home care. Nearly three quarters (74%) of the children who had carers had a better relationship with the carer since receiving the service from Take Two. A small number of children showed no improvement in their relationship with their carer (9%) and for another 17 percent the Take Two clinician was undecided. The only significant difference was that children under the age of 12 years were more likely to show an improved relationship with carers, although the majority of all age groups did show an improvement ($F = 2.78, p < .05$).

11.6.5 Child’s improved relationship with friends and others

Peer relationships and relationships with others were considered by Take Two clinicians to have improved for nearly two thirds of the children (63%), but were undecided about improvements for one quarter (24%). Again, one in eight (13%) showed no improvements in their relationships with friends and others. The only significant difference was that children between the ages of 3 and 12 years were significantly more likely to show an improved relationship with their friends ($F = 2.98, p < .05$).

11.6.6 Child’s improved functioning at school

Among children who attended school or work, two thirds showed improvements in these areas according to the clinicians (67%), with 16 percent being undecided. Whilst not being able to calculate an exact figure, the vast majority, if not all, of these were in relation to school rather than employment. Similar proportions of children as found in other areas of functioning were considered to have not improved in this area of functioning (17%). Children aged three to nine years were significantly more likely to be reported as having improved in their functioning at preschool or school ($F = 3.73, p < .01$).

11.6.7 Child’s improved capacity to cope with adversity

A majority of children from the clinicians’ perspectives showed improvements in being more able to cope with adversity since Take Two’s involvement (59%), whereas 14 percent showed no such improvements in their coping skills. Clinicians were undecided in approximately one quarter of the cases (27%). Young people 15 years or older were significantly less likely to show an improved capacity to cope when things went wrong ($F = 2.61, p < .05$). This was the only significant difference found.

11.6.8 Summary of client changes

Table 44 summarises the areas of client improvement as described by Take Two clinicians for cases open in 2005, not including Secure Welfare. As shown in this table, two thirds of the responses (65%) related to improvements for the children. The three questions relating to the child’s improved relationships with significant people in their lives showed that clinicians rated improvements in these relationships for over half the children, especially for carers. This is a noteworthy positive outcome for a population characterised by attachment difficulties and significant impairment in their capacity to form and maintain relationships (Thomson Salo, Re, & Wraith, 2002).

11.7 Parent changes

Two questions rated changes in relation to parents since involvement with Take Two. These were about whether the parents had a better understanding of the child’s emotional needs and an improved capacity to meet those needs. The mean of these two items was calculated to give an indicator of the overall domain of parent change. Over two thirds (65%) of the children were included in the analysis of this question, with the rest being omitted due to one or both responses answered as not applicable or not known. The possible mean score for overall parent change for these 230 children ranged from one to four with below 2.5 indicating that change had occurred.

Overall, clinicians believed that there had been little improvement in parents’ capacity to understand and/or better meet their child’s emotional and other needs (M = 2.7, SD = 1.1). The two items pertaining to parents were strongly and positively correlated (r = .70, p < .001). However, as seen in Table 45, clinicians rated greater improvements in parents’ understanding of their child’s needs than in the parents’ capacity to meet those and other needs (42% strongly agree or agree compared to 32% strongly agree or agree). This may reflect the chronic difficulties for parents that may or may not have been in the area of Take Two influence; and perhaps their understanding that has not yet been translated into action.

The only significant difference was that for both improved understanding and improved capacity to meet the child’s needs, the children were more likely to be from metropolitan than rural areas (F = 4.90, p < .05 and F = 5.22, p < .05).

<table>
<thead>
<tr>
<th>Area of family improvement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents’ understanding of child’s emotional needs</td>
<td>23 (9.5%)</td>
<td>80 (32.9%)</td>
<td>52 (21.4%)</td>
<td>57 (23.5%)</td>
<td>31 (12.8%)</td>
<td>243</td>
</tr>
<tr>
<td>Parents’ capacity to meet the child’s needs</td>
<td>2 (0.8%)</td>
<td>74 (31.1%)</td>
<td>62 (26.1%)</td>
<td>60 (25.2%)</td>
<td>40 (16.8%)</td>
<td>238</td>
</tr>
<tr>
<td><strong>Average %</strong></td>
<td>5.2%</td>
<td>32%</td>
<td>23.7%</td>
<td>24.3%</td>
<td>14.8%</td>
<td></td>
</tr>
</tbody>
</table>

Note. Clients for whom the question was not applicable, were in the assessment phase or the results were not known were excluded from the analyses.

Table 44

Client Change as Rated by Take Two Clinicians for Cases Open in 2005, not including Secure Welfare

<table>
<thead>
<tr>
<th>Area of client improvement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems have improved</td>
<td>79 (26.2%)</td>
<td>134 (44.5%)</td>
<td>46 (15.3%)</td>
<td>35 (11.6%)</td>
<td>7 (2.3%)</td>
<td>301</td>
</tr>
<tr>
<td>Handling daily life</td>
<td>59 (20.2%)</td>
<td>138 (47.3%)</td>
<td>62 (21.2%)</td>
<td>24 (8.2%)</td>
<td>9 (3.1%)</td>
<td>292</td>
</tr>
<tr>
<td>Relationship with family members</td>
<td>28 (10.3%)</td>
<td>117 (43.2%)</td>
<td>78 (28.8%)</td>
<td>40 (14.8%)</td>
<td>8 (3%)</td>
<td>271</td>
</tr>
<tr>
<td>Relationship with carers</td>
<td>53 (24.3%)</td>
<td>108 (49.5%)</td>
<td>37 (17%)</td>
<td>17 (7.8%)</td>
<td>3 (1.4%)</td>
<td>218</td>
</tr>
<tr>
<td>Relationship with friends and others</td>
<td>37 (13.8%)</td>
<td>133 (49.4%)</td>
<td>65 (24.2%)</td>
<td>27 (10%)</td>
<td>7 (2.6%)</td>
<td>269</td>
</tr>
<tr>
<td>School and/or work</td>
<td>59 (23.4%)</td>
<td>109 (43.3%)</td>
<td>41 (16.3%)</td>
<td>33 (13.1%)</td>
<td>10 (4%)</td>
<td>252</td>
</tr>
<tr>
<td>Capacity to cope</td>
<td>32 (11.3%)</td>
<td>136 (48.1%)</td>
<td>75 (26.5%)</td>
<td>34 (12%)</td>
<td>6 (2.1%)</td>
<td>283</td>
</tr>
<tr>
<td><strong>Average %</strong></td>
<td>18.4%</td>
<td>46.4%</td>
<td>21.4%</td>
<td>11.1%</td>
<td>2.7%</td>
<td></td>
</tr>
</tbody>
</table>

Note. Clients for whom the question was not applicable (such as children who were too young for school or were not in care), were in the assessment phase, or the results were not known were excluded from the analyses.

Table 45

Parent Change as Rated by Take Two Clinicians for Open Cases in 2005, not including Secure Welfare

<table>
<thead>
<tr>
<th>Area of family improvement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents’ understanding of child’s emotional needs</td>
<td>23 (9.5%)</td>
<td>80 (32.9%)</td>
<td>52 (21.4%)</td>
<td>57 (23.5%)</td>
<td>31 (12.8%)</td>
<td>243</td>
</tr>
<tr>
<td>Parents’ capacity to meet the child’s needs</td>
<td>2 (0.8%)</td>
<td>74 (31.1%)</td>
<td>62 (26.1%)</td>
<td>60 (25.2%)</td>
<td>40 (16.8%)</td>
<td>238</td>
</tr>
<tr>
<td><strong>Average %</strong></td>
<td>5.2%</td>
<td>32%</td>
<td>23.7%</td>
<td>24.3%</td>
<td>14.8%</td>
<td></td>
</tr>
</tbody>
</table>

Note. Clients for whom the question was not applicable, were in the assessment phase or the results were not known were excluded from the analyses.
11.8 Carer changes

Two questions rated changes in carers in terms of their capacity to understand and meet the needs of the children in their care. Clinicians were more likely to indicate positive change in these areas following Take Two involvement ($M = 1.8, SD = 0.8, range = 1 to 4$; with below 2.5 indicating change had occurred). The only significant difference was that in relation to carers being better able to meet the needs of children there was less improvement for those caring for children aged between 12 and 15 years than other age groups ($F = 3.71, p < .01$).

There was a strong and positive correlation between these two items pertaining to carers’ understanding and their capacity to meet the child’s needs ($r = .70, p < .001$). However, a discrepancy was again found between improvement in understanding of emotional needs (85% strongly agree/agree) and improvement in capacity to meet the child’s needs, emotional and other (75% strongly agree/agree), as shown in Table 46. This discrepancy highlights the need for support and direct work with carers as well as with families.

### Table 46

<table>
<thead>
<tr>
<th>Area of carer improvement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carers’ understanding of the child</td>
<td>63 (28.9%)</td>
<td>123 (56.4%)</td>
<td>19 (8.7%)</td>
<td>10 (4.6%)</td>
<td>3 (1.4%)</td>
<td>218</td>
</tr>
<tr>
<td>Carers’ capacity to meet child’s needs</td>
<td>47 (21.6%)</td>
<td>116 (53.2%)</td>
<td>40 (18.3%)</td>
<td>10 (4.6%)</td>
<td>5 (2.3%)</td>
<td>218</td>
</tr>
<tr>
<td><strong>Average %</strong></td>
<td>110 (25.2%)</td>
<td>239 (54.8%)</td>
<td>59 (13.5%)</td>
<td>20 (4.6%)</td>
<td>8 (1.8%)</td>
<td></td>
</tr>
</tbody>
</table>

Note. Clients for whom the question was not applicable, were in the assessment phase or the results were not known were omitted from the analyses.

11.9 School changes

Improvements in the capacity of schools to understand (80%) and to respond to the children’s needs (77%) were noted for most clients where applicable as seen in Table 47. An average score lower than 2.5 (range 1 to 4) represents agreement that change had occurred. The average score for school change in this study was 1.9 (SD = .71). Although there were examples where the school’s improved understanding did not translate into improved capacity, these questions were strongly and positively correlated ($r = .74, p < .001$). These results suggest that intervention at the level of the school is worthwhile in creating change for the child. There were no significant differences found in relation to this question and age, gender, Aboriginal heritage and whether they lived in a metropolitan or rural area.

### Table 47

<table>
<thead>
<tr>
<th>Area of school improvement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>School understanding of child’s emotional needs</td>
<td>43 (19.6%)</td>
<td>131 (59.8%)</td>
<td>32 (14.6%)</td>
<td>11 (5%)</td>
<td>2 (0.9%)</td>
<td>219</td>
</tr>
<tr>
<td>School capacity to meet child’s needs</td>
<td>27 (12.5%)</td>
<td>139 (64.4%)</td>
<td>39 (18.1%)</td>
<td>6 (2.8%)</td>
<td>5 (2.3%)</td>
<td>216</td>
</tr>
<tr>
<td><strong>Average %</strong></td>
<td>16.1%</td>
<td>62.1%</td>
<td>16.3%</td>
<td>3.9%</td>
<td>1.6%</td>
<td></td>
</tr>
</tbody>
</table>

Note. Clients for whom the question was not applicable, were in the assessment phase or the results were not known were excluded from the analyses.
11.10 System changes

As with the other areas, two items assessed clinician’s views on improvements in the system’s understanding of and capacity to meet the child’s needs. The system refers to Child Protection, Community Service Organisations and the broader service system. It did not include the specific placement or the school as these were covered in other items.

Overall, the system-related items were rated as showing positive change ($M = 1.8$, $SD = 0.6$, range = 1 to 4 with the score lower than 2.5 representing agreement that change has occurred). As shown by this mean score, more system change was noted than in the other areas. Clinicians rated improvements in the capacity of the system to understand the emotional needs of nearly all clients (90%), and improvements in the system’s capacity to meet the needs of four fifths of clients (82%) as detailed in Table 48. There is a strong positive correlation between these two items ($r = .52$, $p < .001$). Again, this shows that whilst increased understanding is correlated with increased capacity there are a number of situations where one did not lead to the other. There were no significant differences for age, gender, Aboriginal heritage and whether the child lived in a metropolitan or rural area.

### Table 48

<table>
<thead>
<tr>
<th>Area of system improvement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>System understanding of child’s emotional needs</td>
<td>79 (25.9%)</td>
<td>196 (64.3%)</td>
<td>22 (7.2%)</td>
<td>5 (1.6%)</td>
<td>3 (1%)</td>
<td>305</td>
</tr>
<tr>
<td>System capacity to meet child’s needs</td>
<td>42 (14.8%)</td>
<td>190 (67.1%)</td>
<td>40 (14.1%)</td>
<td>7 (2.5%)</td>
<td>4 (1.4%)</td>
<td>283</td>
</tr>
<tr>
<td>Average %</td>
<td>20.6%</td>
<td>65.7%</td>
<td>10.5%</td>
<td>2.0%</td>
<td>1.2%</td>
<td></td>
</tr>
</tbody>
</table>

**Note.** Clients for whom the question was not applicable, were in the assessment phase or the results were not known were excluded from the analyses.
11.11 Changes made by children and their networks

Table 49 provides the means and standard deviations for the client outcome items on the clinician surveys for open cases in 2005. The scale ranges from 1 Strongly Agree to 5 Strongly Disagree. The lower mean scores correspond with greater satisfaction. Percentages in the Agree column are an aggregate of Agree and Strongly Agree and percentages in the Disagree column are an aggregate of Disagree and Strongly Disagree.

<table>
<thead>
<tr>
<th>Questions relating to client outcome since receiving a service from Take Two</th>
<th>M</th>
<th>SD</th>
<th>N</th>
<th>% Agree</th>
<th>% Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take Two has engaged effectively with this child/young person</td>
<td>1.7</td>
<td>0.76</td>
<td>281</td>
<td>87.9</td>
<td>12.1</td>
</tr>
<tr>
<td>The child/young person’s problems have improved</td>
<td>1.9</td>
<td>0.74</td>
<td>255</td>
<td>83.5</td>
<td>16.4</td>
</tr>
<tr>
<td>The child/young person is better at handling daily life</td>
<td>1.9</td>
<td>0.72</td>
<td>230</td>
<td>85.7</td>
<td>14.3</td>
</tr>
<tr>
<td>The child/young person gets along better with family members</td>
<td>1.9</td>
<td>2.15</td>
<td>193</td>
<td>75.1</td>
<td>24.9</td>
</tr>
<tr>
<td>The child/young person gets along better with carers.</td>
<td>1.8</td>
<td>0.65</td>
<td>181</td>
<td>89.0</td>
<td>11.0</td>
</tr>
<tr>
<td>The child/young person gets along better with friends and other people</td>
<td>2.0</td>
<td>0.67</td>
<td>204</td>
<td>83.3</td>
<td>16.7</td>
</tr>
<tr>
<td>The child/young person is doing better in school and/or work</td>
<td>2.0</td>
<td>0.79</td>
<td>211</td>
<td>79.6</td>
<td>20.4</td>
</tr>
<tr>
<td>The child/young person is better able to cope when things go wrong</td>
<td>2.1</td>
<td>0.66</td>
<td>208</td>
<td>80.8</td>
<td>19.2</td>
</tr>
<tr>
<td>The parent/s have a better understanding of the child/young person’s emotional needs</td>
<td>2.5</td>
<td>0.91</td>
<td>191</td>
<td>53.9</td>
<td>46.1</td>
</tr>
<tr>
<td>The carer/s have a better understanding of the child/young person’s emotional needs</td>
<td>1.8</td>
<td>0.61</td>
<td>199</td>
<td>93.5</td>
<td>6.5</td>
</tr>
<tr>
<td>The school has a better understanding of the child/young person’s emotional needs</td>
<td>1.9</td>
<td>0.56</td>
<td>187</td>
<td>93.0</td>
<td>7.0</td>
</tr>
<tr>
<td>Other parts of service system have a better understanding of the child’s emotional needs</td>
<td>1.8</td>
<td>0.53</td>
<td>283</td>
<td>97.2</td>
<td>2.8</td>
</tr>
<tr>
<td>The parent/s are better able to meet the needs of the child/young person</td>
<td>2.9</td>
<td>0.81</td>
<td>176</td>
<td>43.2</td>
<td>56.8</td>
</tr>
<tr>
<td>The carer/s are better able to meet the needs of the child/young person</td>
<td>1.9</td>
<td>0.64</td>
<td>178</td>
<td>91.6</td>
<td>8.4</td>
</tr>
<tr>
<td>The school is better able to meet the needs of the child/young person</td>
<td>1.9</td>
<td>0.55</td>
<td>177</td>
<td>93.8</td>
<td>6.2</td>
</tr>
<tr>
<td>Other parts of the service system are better able to meet the needs of the child/young person</td>
<td>1.9</td>
<td>0.51</td>
<td>243</td>
<td>95.5</td>
<td>4.5</td>
</tr>
</tbody>
</table>

11.12 Summary

Take Two clinicians report effectively engaging with the large majority of their clients. This is an important finding as engagement is a necessary precursor for the child to be able to benefit from the therapeutic relationship. In the opinion of the clinicians, most children were showing improvement in a wide variety of areas including reduction of the child’s problems, improved ability to cope, as well as improvement in the key relationships. An exception to this was the absence of perceived change in the parents’ ability to meet their children’s needs. However, there was noted improvement in parents’ understanding of their children, even if this is not yet translated into action. The perceptions of the clinicians regarding change, summarised in this chapter, provide an important adjunct to other outcome measures.
Chapter 12: Conclusion

12.1 Overview

This report has presented a range of findings arising from multiple data sources informing the evaluation of the first two years of Take Two's operation. This chapter outlines themes drawn from an analysis of these findings and discusses some of the implications. The report builds on the previous evaluation report and provides a first overview at client outcomes.

The evaluation design utilises an action research approach in the undertaking of a process and outcome evaluation. The evaluation framework described in Chapter 2 illustrates the interconnecting components of the Take Two program. Positive developments in each of these components are necessary if Take Two is to meet its aims of assisting children in their process of recovery, achieving safety and developing or sustaining meaningful and nurturing relationships.

The findings of the evaluation contribute to an understanding of the world of the child and identify interventions which engage all elements of the child's system. This report places a spotlight on the components of the evaluation framework such as the focus upon the multiple levels of assessments and interventions and reflective practice and action learning components. Implications of the findings in relation to program implementation, client characteristics; interventions, outcomes and stakeholder and clinician feedback are interspersed throughout the report.

12.2 Summary of findings

Several findings in relation to children, interventions and outcomes have been identified in this report. These include:

- The ongoing program development required for a service such as Take Two.
- Increased capacity to respond to the needs of Aboriginal children through the appointment of a second Aboriginal clinician; the development of an Aboriginal Take Two assessment model; ongoing development of more applicable outcome measures for Aboriginal children; and ongoing collaborations with Aboriginal services.
- Contributing to the assessment and intervention approaches for young people within Secure Welfare.
- Contributing to the child welfare service system through:
  - implementation of a care team approach to support the service system 'keeping the child in mind';
  - introduction of the Help Desk;
  - expansion of secondary consultations; and
  - provision of training to the sector.
- A focus on engagement, assessment and flexible and informed interventions which maintain the centre of attention on the unique needs of the child, and their relationships with parents/carers, family and the service system.
- Ongoing development of the Take Two Practice Framework which emphasises a focus on trauma and attachment theory from a developmental and ecological perspective to inform interventions.
- The continuing picture of the Take Two client group representing severely traumatised children who have suffered multiple types and experiences of abuse and neglect and the impact of cumulative harm.
- The extensive history for many of these children in the protection and care system, such as multiple notifications, multiple placements and multiple attempts at reunification.
- The ongoing vulnerability of the children to new abuse and neglect incidents. This finding highlights the importance of the service system's role to protect the child and the challenge of how to tailor the most appropriate interventions for children whose safety is not yet ensured.
- The consequences borne by many children from the cumulative experiences of abuse and neglect and other traumatic events are evidenced in their range of emotional and behavioural difficulties. These include the majority having at least one mental health diagnosis. There is also evidence of violent behaviour, sexualised behaviours and suicidal ideation. There are concerns regarding developmental harms such as preliminary findings of concerns regarding speech and language development and difficulties with school attendance.
- The interventions utilised by Take Two are multi-faceted and often involve a combination of two or more of the following: individual child work; parent or carer-child dyadic work; parent or carer interventions; family interventions and system interventions.
- Take Two’s work with the service system has been extensive and is reflected in almost all of the cases as well as providing an increasing number of consultations regarding children who are not clients of Take Two.
- There is a high participation rate of the clients, indicating that the vast majority of cases proceed past the initial assessment phase. A very small percentage of cases did not proceed due to the client or family refusing the service. This reflects the creative approaches to intervention and the emphasis placed on engagement with the child and their network.
- The combination of services involved in these children’s lives was evident highlighting the need for services to be complementary as well as collaborative.
- The implementation of measures provided preliminary baseline data that give another description of the children’s emotional and behavioural difficulties and specific trauma-related symptoms. Measures were also used to give voice to the child’s perception of who is in their social world and the importance of these relationships.
- Early trends of positive change for the children in their internal and external worlds were seen to some degree through all the outcome measures, although there is not yet sufficient data to be more conclusive.
- There were high degrees of positive satisfaction from children and their informal and formal networks regarding their experience of the Take Two service. The
majority of stakeholders also commented on the positive outcomes of the Take Two service in relation to specific children.

- Take Two clinicians provided feedback regarding their perception of positive changes observed for the children and their networks.

12.3 Implications of findings and related themes

Although some of the findings in this report are familiar to the field, such as the description of child abuse histories, others are new or unexpected, such as the findings regarding children’s speech and language. All of these findings have implications for the ongoing program development within Take Two, especially in the context of an action research design. They also have implications for the research and evaluation framework. In addition, many of these findings have implications for the broader service system in terms of policy, program development and practice.

12.3.1 Children’s experience of loss, abuse and neglect

The children’s experiences of loss and grief noted in the previous report (Frederico, Jackson, & Black, 2005) were similar to those reported on in this report and underscores that loss is a major part of the lives of many of these children. This loss is reflected in many of the children’s experiences of a death of a parent or other family member, changes in placement and loss of contact with parents and siblings. As such, trauma is not the only theory relevant to the children’s experience of negative events. Theories pertaining to attachment, loss and grief also have relevance for this client group.

The building of the picture of severe and complex histories of abuse and neglect has been a theme of both the first and second evaluation report. The finding that most children have experienced three or more types of maltreatment has emphasised the multiple and harmful nature of these experiences. Case studies portrayed in this evaluation provide a closer look at the mixture of traumatic events and life histories experienced by many children. The majority of these histories reflect both direct serious harms and the sometimes more wearing, cascading effects of cumulative harm. This combination of harms can strip children of potential and actual intra-psychic resources upon which to build resilience as well as be sources of vulnerability and injury.

Children’s experience within the protection and care system can create stability, safety and access to resources for them and their networks. However, as is seen in many child protection systems within Australia and other countries, there is also the risk of additional harms associated with multiple protective interventions and multiple placements. Take Two is rarely involved with children who only come to the attention of Child Protection on a single occasion. In fact those children are rare altogether in the child protection system, both in this jurisdiction and in others (DHS, 2002).

A disturbing finding in this evaluation was the very high proportion of children who had experienced at least one further removal from home after a reunification attempt, prior to Take Two involvement. Although DHS does not measure the amount of reunification or degree of success, the Public Parenting report (DHS, 2003) showed through an analysis of a large sample of cases the degree of reunification breakdown. The findings of this Take Two evaluation appear to be substantially higher than that reported in the Public Parenting report. However, this may be due to that report’s focus on home-based care and the different methodologies in the two studies. Nevertheless, the findings in this study require further analysis of the frequency of reunification breakdowns and the consequences of such on the children.

A reunification experience that has resulted in the child being removed again is not necessarily a detrimental experience for the child. For example, Fein, Maluccio, Hamilton, and Ward (1983) found that children who had been previously reunited and returned to placement did better in any form of permanent placement, including a second attempt at home return. However, other studies have found the reverse (e.g. Bullock, Little, & Millham, 1993). For many children unsuccessful reunifications may reflect further experiences of abuse and neglect; disrupted attachments; heightened fear and anxieties; cumulative harm; perception of failure, self-blame and shame; anger and resentment towards parents and/or the child protection system; lack of trust following sense of betrayal; and lack of hope in the future. Such experiences are likely to exacerbate the children’s sense of loss, confusion and grief. For the parents, unsuccessful reunifications may also represent perception of failure, self-blame and shame; anger and resentment towards the child, and/or the child protection system; heightened fear and anxieties; losing a battle with addiction or other longstanding difficulties; further incidents of violence; and lack of hope in the future.

This high rate of unsuccessful reunification illustrates the need for more attention to be paid to children’s need for stability, as outlined in the new Victorian legislation (Children, Youth and Families Act 2005). Such importance given to stability may be reflected through more supports provided to reunification attempts and more timely decisions regarding alternative case plans. Maluccio, Pine, and Tracy (2002) contend that the high rates of unsuccessful reunifications are another reason for emphasis on strengthening both the child’s and family’s social network.

In this evaluation report the ongoing exposure of a number of children to further abuse and neglect, even once they are in the protection and care system, has been highlighted. This supports the Victorian Government’s policy and program directions to address these issues. It illustrates the need for caution as to when and how to intervene directly with children if their safety is not yet certain. This does not mean that Take Two does not work with children whose safety or security is not yet assured. However, how Take Two works with children in this context is informed by the children’s current situation and their access to a nurturing, consistent carer. When such safety and stability is not yet available, therapy looks and feels different. This finding underscores the extraordinary vulnerability of these children and the imperative of the service system to protect them.

12.3.2 The need for a focus on infants

In this second evaluation, the characteristics of the children and their families only differed slightly from the 2004
evaluation. However, a significant change was the increase in the average age of clients from 11.1 years to 12.3 years of age. The increase in age was coupled with a decrease in the number of infant referrals.

The reduction in infant referrals is a matter of concern for Take Two and for Child Protection, especially given the number of infant referrals in 2004 was already low. This report has shown that consultations regarding infants were also very low compared to other age groups. It is important to explore the reasons why there were so few referrals for infants as this trend goes against the emerging evidence of the importance of intervening with infants and young children.

The brief of Take Two is to work with children from infancy up to 18 years of age and to provide early intervention in addition to addressing long-term issues. The previous report (Frederico, Jackson, & Black, 2005) noted that there may be limited understanding of the mental health needs of infants and toddlers. As such, one of the implications is the need to educate the field about the importance of intervening with young children and what this type of intervention may look like with infants and young children.

“Infant mental health” is defined as the healthy social and emotional development of a child from birth to 3 years; and a growing field of research and practice devoted to:

- promotion of healthy social and emotional development;
- prevention of mental health problems; and
- treatment of the mental health problems of very young children in the context of their families. Zero to Three website (www.zerotothree.org)

12.3.3 Consequences for children's social and emotional wellbeing and development

This evaluation provides insight regarding the children's social and emotional wellbeing through analysis of various data sources. A major approach has been the analysis of the baseline outcome measures. Outcome measures, such as the Social Network Map, Strengths and Difficulties Questionnaire (SDQ) and the Trauma Symptom Checklist for Children (TSCC) provide preliminary baseline information on the intra-personal and inter-personal elements of the Take Two population. Other methodologies such as piloting the screening tool for speech and language difficulties also provided insight into some of the developmental consequences for children. This, in addition to other data such as from the Harm Consequences Assessment and mental health diagnoses, demonstrate the depth and breadth of problems experienced by many of the children. As such they underscore the impact of cumulative harm and the ramifications of multiple types of abuse and neglect on the lives of children. The association between these difficulties and maltreatment is frequently demonstrated in the literature, such as Rowan and Foy (1993) and Putnam (2003) regarding the impact of sexual abuse; Gibbons, Gallagher, Bell and Gordon (1995) and Kaplan, Pelcovitz and Labruna (1999) regarding the impact of physical abuse; Glaser (2002) and Tomison and Tucci (1997) regarding the impact of psychological or emotional abuse; and Perry and Pollard (1997) and Watson (2005) regarding the impact of neglect.

Social Network Maps:

Social Network Maps present the children's perception of their world and their perception of their access to supports. Although there were examples of rich and supportive networks, sadly the findings support the perception of a frequently impoverished social network for many children. Indications of this impoverishment included the absence of key family members such as mothers and fathers; the number of siblings with whom they had minimal contact; the percentage of people who were not known for long periods of time; and the incongruous relationships with peers who were often described as close but not supportive.

Some of the findings are no doubt influenced by the child’s developmental stage. Another hypothesis is that the children perceive these and other limitations to their social networks based on their earlier experiences which led to an inability to trust others. An alternative but not contradictory hypothesis is that they are also influenced by changes in the child’s living and school situation. This has a major implication for children’s resilience to current and future threats as highlighted in Parker and colleagues’ 1997 study. They found that positive friendships were a resilience factor at a time of crisis if the child was not separated from the friends as a result of the crisis. For those children whose lives are beset with placement and school changes their ability to sustain friendships over these times is jeopardised and as such may become a vulnerability factor, as well as a lost opportunity to support resilience.

The important role of siblings and other family members was strongly supported, with siblings and grandparents often being perceived as close. The relatively low proportion of workers listed by children was in contrast to other findings regarding the large number of services involved in these children’s lives. This exemplifies that the Social Network Maps are about the children’s perceptions and that children are more likely to include family and friends rather than professionals as who is important in their lives. A number of children did not perceive workers as supportive. However, others perceived support in the relationships with the service system including with the Take Two clinician and Child Protection worker. The Social Network Map showed the important role of schools with some children identifying teachers as providing them with support, whether or not they were identified as close.

The Social Network Map provides the child with the opportunity to define themselves and others in their world. Implications from these findings include:

- The importance of assessing the children's perception of their world and their key relationships. There is no substitute for asking the child.
- The importance of never forgetting the children’s perception of the importance of their family, whether or not the family are actively present in the child's life. This is consistent with the legislative framework regarding stability and children's best interests whereby, regardless of the children's case plan, their families are likely to remain very important in their eyes. A related implication is the need to include siblings, grandparents, cousins and aunts and uncles in the potential options of support for each child.
- To consider the meaning for children who perceive themselves as cut off from family members and so no
longer mention them. In particular the absence of fathers for many of these children was evidenced in their Social Network Maps and is consistent with findings in various out-of-home care audits conducted by the Victorian government over the past few years. One query is whether the system's lack of attention to fathers has influenced or been influenced by the children's lack of inclusion of fathers in their thinking. The former is considered the most likely. Therefore as the service system becomes more inclusive of fathers this may reduce the number of children who have no or limited contact with their fathers.

• Implementing interventions that focus on specific problems with children's social networks are another important implication. Such interventions are in the purview of both the clinician and case worker. They need to be based on the child and/or family's understanding of their social network and be congruent with culturally sensitive practice (Maluccio, Pine, & Tracy, 2002). They can include the following:
  • help children develop skills in communication and problem solving so that they can better sustain relationships;
  • work on family relationships whether or not the children are living with family;
  • help the family and system to recognise the importance of the children's relationships with siblings;
  • link the child and family into support groups and peer networks;
  • involve children in community activities and give them the interpersonal and financial resources to support their participation;
  • work with parents and carers on the importance of involving children in broader social networks; and
  • directly intervene within the social network context, such as at school to provide a supported opportunity for the children to practise and expand their repertoire of social skills.

Strengths and Difficulties Questionnaire:

One of the key advantages of the SDQ is the ability to see how the child, parents, carers and teachers each view the child's emotional and behavioural strengths and difficulties. The analysis showed that most of the respondents reported the children as having problems in the borderline or clinical range. The majority reported that children had difficulties in three or more areas, such as emotional problems, conduct problems, peer relationships and hyperactivity. Although the young people were likely to self-report less often in the borderline or clinical range compared to other respondents, they still indicated a level of concern. Many respondents, regardless of role, reported that the difficulties experienced by the children impacted on their daily functioning. The respondents who reported the highest number of concerns were parents followed by carers.

This supports other data from the Harm Consequences Assessment which shows that many of the children are struggling with emotional and behavioural difficulties. However, as the SDQ is a standardised measure it enables comparison across other groups. For example, it is evident that emotional and behavioural difficulties were reported more often than what would be found in the general population.

Given the international utilisation of the SDQ, as more data becomes available further analysis will be undertaken in comparing the results to other data sets throughout Australia (such as CAMHS) and in other countries. Preliminary analysis shows that although many of the Take Two clients report in the borderline or clinical range, it is not at the same percentage as those who are referred to a specific mental health service, such as CAMHS. This is understood in the context that presentation of particular problems is not a requirement for Take Two involvement, rather it is the child's experience of trauma which places them at risk of showing such difficulties. Nevertheless, it is still a high proportion within Take Two who show a clinical level of concern.

A key implication from the analysis of the SDQ baseline data is the challenges faced by the children and by those who aim to care for and teach them. The findings show that different people in the child's life, including the children themselves, have different perceptions regarding their strengths and difficulties. This reinforces the utility of using a measure that seeks the perceptions of multiple informants. The challenges for intervention include ensuring that all of those involved in the child's life, starting with the child, feel that their concerns have been heard and understood. As interventions are planned both from Take Two and the broader service system, it is important to focus on those problems which appear to have the most impact on the child. For example, if there are difficulties that are placing the child's placement or school attendance at risk then these may become the priority goals for intervention. Therefore, a practice implication for measures such as the SDQ is to consider the results in conjunction with the broader assessment to inform intervention planning for each child.

Trauma Symptom Checklist for Children:

Nearly half of the children completing the TSCC had at least one valid scale in the clinically elevated range indicating the intra-personal impact of trauma. Trauma-related scales regarding symptoms of depression, anger, dissociation and sexual concerns were more frequently reported in the clinical range. These findings indicate that the children of Take Two are experiencing a high level of traumatisation compared with the general population. However, when compared with the Take Two clinicians' perception of the children's trauma presentation the TSCC data was an under-representation.

Similarly to the other outcome measures, the TSCC provides useful information at the baseline assessment as well as being a measure of change. As such it informs assessment and intervention. An implication for the TSCC and other outcome measures is that the greater the integration of the findings from these measures is incorporated into assessment, the more tailored and goal oriented the intervention planning can be. One of the difficulties with the TSCC as well as the Social Network Map is that they are only self-report measures and there are many children who struggle to complete either one. It is envisaged that the introduction of the Trauma Symptom Checklist for Young Children (TSCYC), which is a parent/carer report measure for children aged 3 to 12 years, will increase the number of
trauma-related measures being completed. The TSCYC will be reported on in the third report as it was introduced to Take Two at the end of 2005.

Other emotional and behavioural concerns
The Harm Consequences Assessment elicits information from referrers about their perception of the children's emotional and behavioural difficulties. The frequency of behaviours such as violence towards others, sexualised behaviours and suicidal behaviours provide another illustration of the level of concern warranted for many of these children. Developmental concerns such as the lack of school attendance also highlight both the level of seriousness and the lack of resources available for many of these children.

Speech and Language
Identification of speech and language difficulties within the Take Two client group draws attention to more developmental aspects of the children’s wellbeing. The findings highlight a high number of children who require formal speech and language assessments. This adds to the understanding of children in the protection and care system and highlights the complexity of the children’s situation and the challenges for intervention. The critical aspect of communication for children is seen in order for them to relate to others; to explore their own feelings; and to express themselves verbally at home or in placement instead of relying on behavioural expression.

A further implication regarding speech and language concerns is the need to ensure developmental assessments inform the broader psycho-social assessment for each child. In turn, such assessments must inform intervention, such as enabling children to have access to specialist assessments when required and incorporating assessment into other interventions, such as helping carers know how to best communicate with the child. This emphasis on development and in particular on language development is also reflected in the outcomes framework articulated in the recent report on ‘the state of Victoria’s children’ (DHS, 2006).

The third evaluation report will include data regarding children's neuropsychological development.

Mental health
Another aspect of the outcomes framework recently developed by the Statewide Outcomes for Children Branch (DHS, 2006) was ‘positive child behaviour and mental health’. This report noted that children involved in the protection and care system were more at risk of having a mental disorder (DHS, 2006). This present study supports this conclusion and findings from other reports, such as the Stargate report (Milburn, 2004). In particular this report noted the presence of trauma and attachment disorders for many children. There was a small percentage of children who had more than one diagnosis. The combination or co-morbidity of particular disorders, sometimes with developmental delays or disability, has not been sufficiently addressed in the literature and research.

Take Two does not require a mental health diagnosis in order to be involved. However, the high proportion of children who had a mental health diagnosis demonstrates their need for access to mental health services. Take Two is a relatively new member of the therapeutic service system, which includes CAMHS services, sexual assault services and other non-government and private therapeutic services.

Over a quarter of Take Two clients saw a worker from another therapeutic service during Take Two involvement. In some cases this was a transition from one service to another. In other instances this reflected an agreement that more than one service was required. For example, where the children needed mental health case management from CAMHS in order to monitor their medication and to access inpatient treatment as required, but also needed system intervention and outreach work that was more able to be undertaken by Take Two.

There remains some confusion regarding the ‘ideal’ interface between Take Two and other therapeutic services. As there is a greater level of need than any of the services can meet on their own, the key appears to ensure there are not gaps in service delivery and that any lack of clarity does not translate to poor service delivery or coordination.

12.3.4 Engagement, assessment and intervention
Interventions utilised in Take Two are diverse with the intention to orchestrate such interventions around a unifying framework. Much of the literature regarding interventions with children focuses on individual therapeutic approaches and to a lesser extent family intervention. An exception is the literature regarding Multi Systemic Therapy (e.g. Hengeller, Pickrel, Brondino, & Crouch, 1996). However, most of this literature is written regarding intact parent-child dyads where the child has never been removed from the parents’ care. A few authors who write specifically on therapy with children in out-of-home care include systems interventions as a cornerstone of their approach. For example, Henggeler and colleagues (1996) write of the importance of involving the informal and formal systems around the children. Dozier, Dozier, and Manni (2002) have written of the work with caregivers around psycho-education of the needs of children in their care. Perry (2006) writes of the importance of developing a therapeutic web around traumatised children so that carers, teachers, workers and families all provide the same repetitive messages of care, nurture and safety.

This evaluation describes the considerable amount of work undertaken by Take Two with the service system involved with the client group. The initiative of care teams has provided an improved structure for such work. Other elements of system intervention include psycho-education of carers, teachers and other workers; advocacy reflecting the voice and needs of the children; and shared problem-solving and support of the service system’s goal to meet the children’s best interests. The case studies demonstrate a strong focus of working with the service system to influence change in the child’s environment and support the therapeutic intervention. Client activity records show the frequent use of systems intervention undertaken on a case by case basis.

It is too early to peer into the ‘black box’ to understand what it is that works in therapy. However, the evaluation has gathered detailed information on engagement, assessment and intervention activities and this presents a preliminary guide to understanding what occurs in therapy. This has built on work undertaken elsewhere within Take Two and through the consultation conducted by Ryan and Jones (2005). The continued development of the Practice Framework will allow for a greater understanding of what is
an effective intervention. A challenge for Take Two will be ensuring the organisational culture encourages consistency with the interventions within such a framework.

The very high proportion of cases that proceeded despite many of the children having experienced past difficulties in trusting adults and forming relationships has been highlighted. The major increase in cases being closed due to Take Two completing its role also supports the focus on engagement, persistence and creativity. The principle of Take Two accepting responsibility for engagement and the strategy of working through key relationships when children are not yet ready to be directly engaged have been supported by this report. It endorses the increased attention that Take Two has paid to the process and timing of closures. This is noteworthy given the volatile nature of this client group and their chaotic life circumstances which can make it difficult to follow through planned interventions. It suggests that in many cases, Take Two clinicians were able to work through a planned intervention and complete their work at an appropriate time for the child and their network.

As some of the case studies have shown, Take Two’s completion of work cannot be interpreted as the child not requiring further intervention for ongoing support of the child or his or her network. Rather it may be an acknowledgement of the child and his or her family’s need for more long-term, but less intensive, support once sufficient gains through more intensive therapy have been made.

As Take Two has moved from the establishment and implementation phase to the ongoing operational focus, it has paid increasing attention to systems and practices that support timeliness in assessment, intervention and closure. This will be further enhanced when the Take Two computerised client information system becomes operational.

12.3.5 Early trends of positive change for the children in relation to their internal and external worlds

Although it is too soon to draw conclusions from the findings about outcomes, the trend from the different measures is consistently towards positive change. These findings are drawn from multiple sources of data, such as the SDQ, TSCC, Social Network Map and stakeholder feedback and clinicians’ reports.

Social Network Maps:

In relation to the Social Network Maps, although there were a low number of repeat measures, they highlighted changes in the children’s perception of their social supports in the majority of cases. In particular they described more people as ‘very close’ over the two time periods. It will be interesting to see if this pattern continues or changes as more data are received. It is envisaged that as more Social Network Maps are completed for this client group, more will become apparent in terms of what types of changes can be observed over time.

Strengths and Difficulties Questionnaires:

The preliminary data regarding the SDQs show a trend towards improvement, from all data sources, although most of the results are not yet statistically significant. Those areas that did show a significant difference were the SDQs completed by carers who noted a significant improvement in the children’s conduct problems, hyperactivity and in the total difficulties score. The small sample size and the variation of timing of the administering of the measures may have impacted on the lack of statistically significant change at this time.

Trauma Symptom Checklists for Children:

The data in relation to the TSCCs also show positive trends, although the data are preliminary. There was a reduction in reported symptoms in every scale of the TSCC over the two time periods and in the number of children who moved from the clinical range to the non-clinical range over the two time periods. Although promising, it is too early to make conclusions until further measures are received.

The stakeholder and clinician surveys:

Other indications of change were reported from the use of the client and other stakeholder’s survey and the survey completed by Take Two clinicians. These support the view that positive change is occurring. Feedback received from those who responded to the stakeholder surveys more frequently noted change than the clinician surveys. This may be a factor of respondent bias as it has been found that clinicians are less likely to note change. It may also be related to the different samples, whereby stakeholders were sampled whereas all clinicians were required to send in surveys. As the stakeholder surveys were anonymous it was not possible to tell if these cases were at the closure phase. As such there may have been a factor of a difference in time across the two groups which is not possible to analyse.

The clinician surveys included questions regarding change in the children’s emotional and behavioural problems, and also in the parents’, carers’ and schools’ ability to understand and respond to the children’s needs.

The stakeholder feedback not only provided the points of view from the children, carers, parents and teachers, but also heard from case managers and other workers regarding their perspectives on change. The open-ended questions encouraged different feedback to that directly elicited from other aspects of the surveys or other outcome measures.

The revised version of the stakeholder feedback has been instituted within Take Two at the time of writing this report. This will provide more capacity to compare responses as these surveys are no longer anonymous.

12.3.6 Positive satisfaction from children and their informal and formal networks regarding their experience of the service

This evaluation has involved the use of stakeholder feedback processes and the piloting of survey designs. The feedback of over 250 children, families, carers and workers has provided a valuable source of information not otherwise available. This has provided an opportunity to explore the association between satisfaction with a service and perception of outcomes for children. For every type of respondent and for every question, the majority agreed or strongly agreed that they were either satisfied with the Take Two service or that the service led to positive outcomes. The respondents varied within these results with parents usually expressing the least amount of agreement and workers
being most likely to agree in relation to both satisfaction and outcome-related questions. The higher degree of satisfaction compared to outcomes is consistent with results from other studies.

The open-ended comments also enabled a wider range of responses as exemplified in the children’s comments which ranged from the Take Two clinician ‘learning more about my life’; talking ‘about my life and how to get along with people’; and helping ‘me with my big problems’.

12.3.7 Increased capacity and capability to respond effectively to the needs of Aboriginal children

The over-representation of Aboriginal children in the Take Two client group, although reflective of the over-representation in the broader protection and care system, requires ongoing attention. It represents both the historical and current patterns of harm that have been experienced by Aboriginal people and their community. Take Two’s Aboriginal team has been the vanguard to Take Two’s response to these children and their families; either directly or through their support of other Take Two teams in their clinical work. There has been an increase in referrals both to Take Two overall, and the Aboriginal team in particular. Doubling the size of the Aboriginal clinical team from one to two workers is a clear indication that Take Two is committed to finding effective ways to work with these children in a culturally appropriate way. Nevertheless, the number of referrals regarding Aboriginal children continues to be considerably larger than the capacity of the Aboriginal team.

The creation of a Take Two Aboriginal assessment framework by the Aboriginal team is a key component in the development of effective interventions for Aboriginal children and is an example of how this team is impacting practice across Take Two.

Another indication of Take Two’s continued development is the strengthening links with Aboriginal organisations, such as VACCA. Again the Take Two Aboriginal team has been pivotal in this networking and opportunities for partnership regarding research have also been valuable.

12.3.8 Contribution to the assessment and intervention approaches to Secure Welfare clients

The demand for Take Two’s role in the Secure Welfare Service has continued to increase over the two years. Alongside this increase in demand has been the very positive regard for the service as shown through the feedback from stakeholder surveys and a focus group. The value of Take Two’s role within the Secure Welfare Service has been endorsed by the recent decision by DHS to increase the funding of this part of Take Two’s role. The role of brief therapeutic intervention in the context of a unique service such as the Secure Welfare Service will continue to be an area of analysis and discussion.

12.3.9 Comparisons between work in the metropolitan and rural areas of Victoria

Although most of the children involved with Take Two are from metropolitan Melbourne, the work in the rural areas continues to pose specific challenges that require attention. The data show some demographic differences regarding age group and type of placement. However, the more apparent differences are in the small team structures and, in three rural regions, teams that have had to split to meet local requirements. This had led to more issues, such as economies of scale, constraints regarding travel time and access to team and program supports including supervision. In the first year of operation, this appeared to have exacerbated some delays in recruitment in some rural regions. This is an ongoing issue requiring proactive management and consideration of how best to support the work of these smaller teams with larger catchment areas.

12.3.10 Contribution to the broader service system through the implementation of approaches such as the Help Desk and care team

Considerable discussion has occurred as to how Take Two can contribute to the way the service system, of which it is a part, plans for and intervenes with children who have experienced trauma and deprivation. The different stories can sound familiar and one of the challenges is to keep each child in mind and acknowledge his or her individual experiences. Take Two’s objective regarding contributing to the service system is both case-related and system-related.

Functions such as increased consultations and the instigation of the Help Desk approach are examples of strategies put in place to assist services in their work with children. Some of these involve more than one consultation and may occur with individual workers or a residential team or other work group. Other consultations have been more focused on whether or not the situation and timing is appropriate for referral to Take Two or may require alternative strategies. The Help Desk approach in particular has been a systematic approach to assist in both the referral and consultation process. The Help Desk has enabled Take Two to engage primarily with Child Protection practitioners to identify appropriate referrals and to provide secondary consultations. This approach has also been utilised with VACCA in relation to Aboriginal clients. However, there is not current capacity to provide this mode of working with other Community Service Organisations.

The implementation of the care team approach was another key platform in 2005. It reflected the reality that no service is able to effectively plan for, support, nurture, care, teach and/or work towards recovery in isolation. Different services can unwittingly undermine each other in their respective goals if they are not proactive and collaborative. Take Two’s role in this process has been to introduce or support the notion of the care team being a virtual team that keeps the child ‘in mind’ and as such, keeps the other services’ roles ‘in mind’.

On a broader level, there is positive feedback regarding the training Take Two has provided to the child protection and child welfare sector. The staff journals indicate the challenges sometimes experienced by Take Two staff in working with Child Protection and the service system, such as when a case is unallocated. However, there is also appreciation of the work of Child Protection staff, the broader service system and in particular the difficult role of carers. The difference that committed carers can make to the outcomes for a child was emphasised.
12.3.11 Ongoing development of the Take Two Practice Framework including the focus on trauma and attachment theory to inform interventions

There have been a number of important program developments which are aimed at providing greater support for the clinical teams in their work with and for the children. Some of these have already been discussed, such as the appointment of an additional Aboriginal clinician, care teams and ongoing development of the Practice Framework. Continued focus on training for Take Two and the service system is also illustrative of a developing Take Two program model.

There were three major developments of the program implementation in 2005 which furthered the conceptual development of Take Two. These were the introduction of a common assessment tool, the ongoing development of the Practice Framework and implementation of the Outcomes Framework and measures. These developments have been supported by staff development. The impact of these developments was only beginning to emerge in 2005. The evaluation has been able to trace these developments particularly through staff journals where their positive and challenging aspects were commented upon.

The further development of the Outcomes Framework and client outcome measures in 2005 was the next stage in the process of the action research model. Integration of these measures into the work of Take Two has required the development of a culture regarding the clinical and research purposes of outcome measures and systems to support their implementation. The Outcomes Framework and the Practice Framework are being developed in tandem and as such have informed each other. For example, the concept of the therapeutic grid which is being initiated within Take Two to help inform intervention was tested out in the Take Two clinician survey in this evaluation. As a result, the evaluation has been able to report on the clinicians’ perspectives about the interface between the children’s presentation of traumatisation and their access to consistent and nurturing carers or parents who can support them during therapy. These data will also inform further development of the Practice Framework as it attempts to spell out the components of the ‘black box’ regarding what actually happens in a Take Two intervention. The diversity of interventions highlighted in Chapter 5 has a common theme of holding the child’s needs as the central concern in therapeutic intervention and engaging with the informal and formal systems surrounding the child.

12.4 Overall summary

The first two years of Take Two’s operation have signified achievement of the core programmatic goal of establishing a therapeutic program with centralised management and locally based services throughout the state. Collaborative relationships with Child Protection and the broader sector have also been developed.

This report has demonstrated the complexity and vulnerability of the client group thus reinforcing the need for tailored therapeutic services. Complexity is not only a characteristic of the child’s experience and presentation, but also denotes their informal and formal networks including the service system.

Children’s journeys of recovery from trauma and deprivation are each unique yet share some themes in common. Their journey through the service system and its impact is highlighted in this report. The critical nature of relationships, both within their broader social world and therapy, is a key theme in this journey. The therapeutic relationship may form a bridge that enables the children and their parents or carers to strengthen their relationship. Enabling children and their networks to understand their experiences and the resultant emotions and behaviours is another key role in therapy. It is giving words to these experiences that can help the children to make sense of their situation and/or those responsible for caring for them. The child’s development and trauma presentation influence whether the journey begins with the child, his or her carers, the broader system or a combination of these approaches.

Signs that Take Two is making a difference to the internal and external world of children are promising. Findings from multiple data sources are all in a positive direction. However, the low number of outcome measures means that definitive conclusions cannot yet be drawn from these data. This limitation is balanced by the findings of the qualitative data such as the case studies, clinician surveys and stakeholder surveys which illustrate strong positive outcomes for children. Furthermore, the evaluation has been able to highlight the building of a Take Two program which addresses all the components described in the evaluation framework and is continuing to work in collaboration with the service system to meet the needs of this extremely vulnerable population.
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Appendix One:
Summary of findings

Chapter 3: Ongoing implementation of Take Two
Structure of the Take Two program
- Take Two had been established throughout Victoria. In 2004 12 clinical sites were set up in metropolitan and rural areas and in 2005 a further site in Horsham was established by an internal move of a clinical position.
- The Aboriginal team was expanded from one to two clinical staff in 2005.

Ongoing development of the Take Two Practice Framework
- The ongoing development of the Practice Framework was a major task during 2005. This included a review of the framework and of Take Two staff’s perceptions of appropriate interventions. This review was sponsored by the Training Manager and undertaken by external consultants.
- The development of the Practice Framework included the concept of a therapeutic grid. The development of the grid was informed by research findings that indicated the importance of assessing children’s trauma presentation alongside the availability of a nurturing consistent carer and in the context of the child’s development and ecological systems to determine the most appropriate form/s and timing of intervention.

Program development regarding Take Two’s work with Aboriginal children
- The expansion of the Aboriginal team enabled more children to be directly allocated to an Aboriginal clinician. However, given the continuing high rate of referrals of Aboriginal children most were still seen by non-Aboriginal clinicians. This emphasises the need for ongoing collaborative work between the Aboriginal team and the regional and Secure Welfare teams within Take Two. It also illustrates the importance of ongoing collaborative working relationships with Indigenous services such as the Victorian Aboriginal Child Care Agency (VACCA) and the Victorian Aboriginal Health Service.
- The ATSI assessment tool was developed by the Take Two Aboriginal team to ensure more comprehensive and culturally appropriate assessments are conducted by non-Aboriginal Take Two clinicians with Aboriginal clients. All Take Two staff were trained in the use of the tool.

Program development regarding Take Two Secure Welfare role
- The Secure Welfare Service is unique within Australia and though there are some points of comparison internationally it appears unique in the world. Take Two is a relatively new element within this service and works alongside the Secure Welfare Service, CAMHS and other colleagues to enhance the therapeutic component of this service. The evaluation highlights the value of the juxtaposition of Take Two and the Secure Welfare Service.

Contributing to service system improvement
- Help Desk: Take Two established a Help Desk approach in all regions whereby a more regular and visible process of consultation and discussion regarding potential referrals with Child Protection was developed. These Help Desks sometimes took the form of a regular time and presence in a particular Child Protection office and at other times reflected an agreed upon time when Take Two was available for phone consultations with Child Protection. The Aboriginal team implemented a similar model within VACCA.
- Care team: Although care teams are not unique to Take Two, they became a major platform for systems intervention during 2005. Care teams involve regular meetings with a child’s key workers and where possible their carers to ensure that all involved are together keeping the ‘child in mind’.
- Take Two staff participated in network meetings, reference groups and program and service system development processes throughout the state.
- Take Two staff provided training related primarily to trauma and attachment to Child Protection, Mental Health and Community Service Organisation workers. Take Two has also provided conference papers and education sessions in academic institutions both in Victoria and in the United States.

Training received by Take Two staff
- Friday Focus, which is a regular internal training day for Take Two staff, consistently met its aims, with positive feedback from most clinicians. Satisfaction with the Friday Focus training improved in 2005 compared with 2004.
- By the end of 2005 most Take Two clinical staff had completed training in child and adolescent mental health regarding assessment and intervention. This training provides a shared platform with CAMHS of understanding the mental health of children and young people.

Research
- An outcomes framework was developed in 2004 that outlined domains of change that were likely to be sought for children referred to Take Two. Outcome measures and other instruments to describe outcomes were selected or developed and implemented in late 2004. Training and other approaches to facilitate the implementation of these measures was instigated in 2004 and continued throughout 2005.
- In 2005, La Trobe University, VACCA and Take Two began research funded by AIATSIS regarding assessing the social and emotional wellbeing of Aboriginal children.

Chapter 4: Description of client group
Cases accepted by Take Two
- For the years 2004 and 2005, 585 cases were accepted in Take Two. The total number of open cases for 2005 was 462. Take Two met 84 percent of the target of cases for 2005.

Cases closed by Take Two
- There was a large variation across teams regarding the number of cases closed in 2004 and 2005. Secure Welfare had 100 percent closures due to the brevity of the role. Other teams ranged from 57 percent of cases closed to no closures in this time period. There was no difference between metropolitan and rural teams in terms of proportion of cases closed. The overall rate of closures increased over the two years. The amount of time closed cases had been open among regional or Aboriginal teams was, on average, ten months, with a range from less than three months to two years.
- The most common reason for case closure was the completion of Take Two’s role. The next most frequent reason for closure was another service being deemed more appropriate than Take Two. A smaller proportion were closed because Child Protection had closed the case and a similar proportion were closed due to the client refusing Take Two service, though all of these were cases referred in 2004.
- The reasons for case closures changed considerably over the two years with a higher percentage of cases closed due to completion of Take Two’s role in 2005 compared to 2004. This was an increase from just over half to over four fifths of closed cases. In contrast all the other reasons for closure reduced in
frequency. These changes suggest a positive trend in more appropriate referrals being made to Take Two over time and ongoing development of Take Two practice.

**Daily average number of cases**
- The target of the number of clients Take Two was expected to see on a daily average was 297 clients. In 2005, 80 percent of the annual target was met. There was a clear pattern of an increasing daily average; from 70 percent to 89 percent of the target over the year.
- This increasing daily average of clients reflects an increased workload per Take Two clinician that occurred in both rural and metropolitan teams. The caseloads, however, continued to reflect the complexity of the role and the interventions required for many of these children.

**Repeated referrals to Take Two**
- Take Two has continued to meet the target of having considerably less than ten percent of re-referrals within 12 months of case closure.

**Age and gender of Take Two clients**
- The age of clients increased from an average of 11.1 years in 2004 to an average of 12.3 years in 2005.
- Infant referrals in 2005 made up an even smaller percentage than in 2004. Given the proportion of infants in Child Protection is high and the imperative of intervening early in life, the dearth of infant referrals is a major concern.
- In 2004 and 2005, just over half of Take Two clients were male; however, this is a significant reduction in the percentage of males from 60 percent in 2004 to 40 percent in 2005. This primarily represents a significant increase of young women involved with Take Two in Secure Welfare, as the majority of other teams continued to work with more males than females.

**Aboriginal children**
- Take Two worked with 90 (15%) Aboriginal children in 2004 and 2005. This is an increase from 14 percent to 17 percent over the two years. It represents a 1400 percent increase over-representation compared to the number of Aboriginal children in the general Victorian population (ABS, 2001). This figure is consistent with the over-representation of Aboriginal children in the protection and care system, but is nevertheless of major concern.
- In 2004 and 2005, all teams were working with one or more Aboriginal clients. In terms of numbers, Secure Welfare had the highest number of Aboriginal clients. The Aboriginal team only worked with Aboriginal clients. The Gippsland team had the highest percentage of Aboriginal children compared to other regional teams.
- Over two thirds of Aboriginal clients in 2004 and 2005 were 12 years or older. Their mean age was significantly older than non-Aboriginal clients.
- No Aboriginal infants were referred to Take Two. Given the high birth rate within the Aboriginal population and the high percentage of Aboriginal infants in the protection and care system, this indicates a significant under-representation of Aboriginal infants referred to Take Two.
- Unlike the Take Two client population as a whole, just over half of the Aboriginal children were female.

**Siblings**
- There was an average of 2.6 siblings per child involved with Take Two in 2004 and 2005. Half of the children had three or more siblings.
- Among those who had at least one sibling, two thirds were not living with any of their siblings. Among children who had at least one sibling, over four fifths had at least one sibling who was also a client of Child Protection.

**Children living in rural or metropolitan settings**
- Two thirds of the children involved within Take Two in 2004 and 2005 were living in metropolitan Melbourne, compared to a rural area.
- Children living in rural areas were significantly likely to be younger. Children living in a metropolitan area were more likely to be living at home or in residential care compared to children living in rural areas. Children in rural areas were more likely to be placed in kinship care or home-based care.

**Children’s experience of loss and grief**
- Fifty-two children (14%) who were clients of Take Two in 2004 and 2005 had a parent or parent figure who was deceased.
- At least another 12 children had one or more siblings who were deceased.
- This reality combined with many of the children’s separation from their parents and siblings and histories of multiple placements and reunification attempts emphasises their experience of major loss and grief.

**History of Child Protection involvement prior to referral to Take Two**
- The large majority of children have extensive histories of Child Protection involvement. For example, more than 90 percent have more than one notification with half having five or more previous notifications. Two thirds of the children had been on a court order before their current order.
- Adolescents are more likely to have an extensive protective history compared to children six years or younger. However, children between the ages of 6 and 12 years are likely to have a similarly extensive history of Protective involvement as adolescents. There was no significant difference in relation to age and the number of court orders. In other words, infants were likely to have been placed on almost as many court orders as older children.

**History of children's placements prior to referral to Take Two**
- The vast majority (94%) of children referred to Take Two in 2004 and 2005 were on a Children’s Court order at the time of referral; most of which were Guardianship or Custody orders reflecting an extensive level of system involvement.

**Child Protection involvement at time of referral to Take Two**
- Less than ten percent of children had not had a previous placement at time of referral to Take Two. The majority of children had five or more previous placements.
- A small yet concerning number of children had experienced a breakdown of a permanent care placement.
- Nearly two thirds of the children had experienced one or more attempts at reunification.
- A very concerning finding was that over 90 percent of those who had been reunited with one or both parents were subsequently removed from home at least one further time. As such, most of the children have experienced unsuccessful attempts at reunification and the associated loss and confusion.

**Child’s placement at time of referral to Take Two**
- At the time of referral to Take Two, four fifths of the children lived in some form of out-of-home care. The majority were either in home-based care or residential care. Fifteen percent were in kinship care.
- Although children under the age of 12 years were more likely to be in home-based care, three children under the age of six years were in residential care.
Case contracting case management
- The percentage of children where case management was contracted to Community Service Organisations is considered low at 18 percent.

Child Protection case plan goals at time of referral to Take Two
- Reunification is the most frequently stated Child Protection case plan goal.
- For nearly half of the referrals to Take Two, reunification or children remaining with their families were case plan goals, indicating that families have some level of involvement. However, when goals for long-term placements and permanent care are combined this was a higher percentage than reunification. This illustrates the other side of the coin; that is, that many of these children have case plans reflecting a reduction in family involvement.

Description of young people involved in the Take Two Secure Welfare Service
- There were 197 admissions of young people in the Secure Welfare Service who were clients of Take Two over 2004 and 2005. This represents a 21 percent increase over the two years. The 197 Take Two Secure Welfare admissions related to 156 young people, indicating multiple episodes of Take Two involvement for some of these young people.
- The increase in Secure Welfare cases for Take Two is consistent with the trend of increased admissions to the Secure Welfare Service in general. Over the two years the proportion of young people in the Secure Welfare Service who were clients of Take Two slightly increased to just over two fifths of the overall Secure Welfare Service population.
- The average age of young people involved with Take Two Secure Welfare over the two years was 15 years with no change between the two years.
- In 2004 and 2005 over half the Take Two Secure Welfare client group were female. This was a similar proportion to the overall proportion of young women in the Secure Welfare Service. However, the pattern had changed within these years. Both the Secure Welfare Service in general and the Take Two role within Secure Welfare saw an increase in the numbers and percentage of young women in 2005 compared to the previous year, with this being a larger change for Take Two.
- Eighteen percent of young people involved with Take Two in Secure Welfare were Aboriginal in 2004 and 2005. This represented a reduction over the two years, but was still a significant over-representation. The proportion of Aboriginal young people in the Secure Welfare Service generally also reduced, although was still high. The over-representation indicates that Aboriginal young people are either at greater risk; are perceived at being at greater risk; and/or are more likely to be placed in a secure facility than non-Aboriginal young people.
- Once age was taken into consideration there was no significant difference in Child Protection histories between the young people involved with Take Two in Secure Welfare and the overall Take Two client group.
- Just over half the young people involved with Take Two in Secure Welfare over these two years were on Custody to Secretory orders, a quarter were on Interim Accommodation orders and less than a fifth were on Guardianship orders. This pattern did not change over the two years and was consistent with the general Secure Welfare population.
- Prior to admission to the Secure Welfare Service, over the two years half the young people were in residential care, with the next highest number living with one or both parents, followed by those living in home-based care.
- The use of the Secure Welfare Service in general and for Take Two’s role within Secure Welfare varies considerably by Child Protection region, with three quarters of referrals coming from metropolitan regions.
- Over the two years, the average length of stay per Secure Welfare admission for young people involved with Take Two was nine days, similar to the general Secure Welfare Service population.

Experiences of abuse and neglect prior to referral to Take Two
- Nearly all children have suffered emotional and psychological abuse (97%). The large majority have suffered abandonment or inadequate parenting (84%). A large majority had also experienced some form of physical abuse (83%). Sexual abuse was the least frequently reported, but still reported in relation to 41 percent of children.
- When neglect was considered as a separate type of harm, 98 percent of the children experienced at least one form, such as emotional neglect, physical neglect and developmental neglect.
- Younger children were more likely to be exposed to family violence and parental illness than adolescents. It may be that the system focuses more on the behaviours of adolescents than on the harmful events they experienced earlier or even later in life.
- Children who had suffered only one of the five types of maltreatment were a small minority, representing only four percent of Take Two clients. Nearly two thirds of Take Two clients had suffered four or five types of maltreatment. This extensive history of abuse and neglect demonstrates the multiple experiences of trauma and deprivation for the vast majority of these children highlighting the added difficulties they are likely to experience in their process of recovery.

Experiences of abuse and neglect and/or trauma since Take Two involvement
- According to Take Two clinicians, new incidents of abuse or neglect occurred for nearly a third of the cases involved with Take Two in 2005.
- Over half of these incidents were perpetrated by a parent or parent-figure, such as during an access visit or reunification. Over a fifth occurred while the child was in out-of-home care, mostly by carers and a small percentage by other children in care.
- Emotional and psychological harm was the major form of abuse of children during Take Two involvement, occurring for just over a fifth of cases. One in eight children had some form of physical harm.
- Clinicians reported maltreatment during Take Two involvement for significantly more children in metropolitan than rural areas.
- New incidents of maltreatment were reported for significantly more infants and young children than adolescents. Fifty percent of children under three years had some reported maltreatment occur whilst Take Two was involved; and 38 percent of children aged between three and six years. This heightened exposure to ongoing harm coupled with the heightened vulnerability associated with infancy is of serious concern.

Consequences of abuse and neglect
- The range of consequences for children in terms of their emotional, behavioural and other developmental wellbeing was extensive, with more than four fifths of the Take Two client group having three or more domains affected.
- Emotional harms were noted for almost all of the children followed by the related area of feelings associated with...
abandonment and lack of security. Developmental harms were noted for nearly three quarters of the Take Two population. Examples included the children absconding, criminal activity, changes in affect or mood, deterioration in attention and in particular repeated and severe violence towards others. An example of such a concern is the 83 percent of adolescents who were described as having repeated and severe violent behaviour towards others.

- A fifth of the Take Two client group in 2004 and 2005 were described at time of referral as exhibiting one or more sexualised behaviours towards others. There were mixed results regarding age and gender differences depending on the type and severity of the sexualised behaviours.

- In 2004 and 2005 a fifth of the Take Two client group were described as having attempted suicide or having suicidal ideation. The vast majority of these were adolescents. Young people in Secure Welfare were particularly acknowledged to be at risk.

Mental health

- Nearly two thirds of children involved with Take Two over the first two years met the criteria for at least one mental health diagnosis. One in six children met the criteria for two or more diagnoses. Multiple diagnoses (co-morbidity) are frequently noted in the literature regarding consequences of abuse and neglect.

- Mental health disorders relating to attachment and traumatisation were the most frequently reported diagnoses.

School involvement at time of referral to Take Two

- The majority of school-aged children were enrolled in school. Those not enrolled were most commonly post the compulsory age of 15 years.

- In contrast, nearly a third of the Take Two client group were described as having a serious lack of or no attendance at school, most of whom were in the compulsory school-age group.

Speech, language and hearing development and functioning

- Over 100 Take Two clients were sampled regarding speech and language difficulties using a draft screening tool. More than four fifths of this sample showed indication of needing further assessment. In a more conservative approach to the analysis, two thirds showed the need for speech and language assessment. Children aged between 12 and 15 were more likely to be assessed as needing further assessment than the next highest group of children aged between six and nine.

- The screening tool required further adaptation to more effectively pick up issues for infants.

- In comparison to the high proportion of this sample requiring further speech and language assessment, less than a fifth of those referred to Take Two had speech or language problems identified by the referrer. One hypothesis is that communication problems are not always understood or easily identified. The screening tool included items that are not necessarily understood as indicating the need for assessment, such as poor literacy.

- Boys were more likely to be identified with two or more speech or language concerns than girls. This is consistent with the general literature regarding gender issues and speech.

- Obvious speech problems such as stuttering are not the only indicators of speech and language problems. Poor literacy, eating problems, social problems and difficulties in telling stories are other examples that can indicate the need for speech and language assessment. They are also potentially indicative of other concerns, such as exposure to trauma or neglect, which again highlight the need for assessment.

Chapter 5: Interventions

Desired outcomes according to referrers

- Just over half of the desired outcomes according to the referrer related to the child wellbeing domain, such as helping the children to recover from their experience of trauma and reduction of emotional and behavioural symptoms. This was followed by outcomes relating to strengthening family and community support; enabling stability; security and connectedness; and child safety, which primarily focused on reducing the behaviours of the children that jeopardised their safety.

Take Two’s activity related to clients in 2004 and 2005

- The largest component of clinical staff’s time was spent in interventions with the children, families and carers. The next largest component was the time spent in system-related interventions. A fifth of clinical time was spent in supervision, which accounted for both the supervisor and supervisee time.

- The type of direct service accounting for the largest percentage of time was intervention with children on their own, followed by assessment with the children.

- Service delivery occurred in a variety of settings. Half of staff’s time providing direct service took place at Take Two offices.

Cases that did not proceed past preliminary involvement

- Almost all cases (94%) open in 2005 proceeded past preliminary involvement. Of the cases that did not, less than two percent were due to the child or family refusing to participate. Other reasons for not proceeding were due to changes in Child Protection decision-making or the child leaving the state. The only significant difference was that the small number of cases that did not proceed were more likely to be adolescents than younger children.

Clients or families refusing involvement

- Fifteen cases open in 2005 were closed either in the preliminary stages or at a later point due to the child or family refusing ongoing Take Two involvement.

- This 96 percent participation rate would be extremely positive for most populations but is extraordinary for children and families where abuse and trauma have occurred. This endorses the emphasis Take Two places on taking responsibility for engaging the child, family and carers.

- The child’s age was the only factor that showed a significant difference between whether or not the child was likely to refuse a service, with the majority of those refusing being adolescents.

- The only significant finding regarding families refusing a service was that none were from rural areas.

Take Two interventions in 2005

- A multi-faceted approach was utilised with most Take Two clients in 2005. This usually involved a combination of individual work with the child, joint work with the child and others in their life and work with other parts of the system.

- Individually focused child therapy occurred with over two thirds of the clients. Overall children were directly seen in either individual and/or family-based interventions in nearly four fifths of open cases in 2005.
• For nine tenths of open Take Two cases in 2005, work was done directly with the child, parent, carer or a combination of the above. The remaining cases had a focus on assessment or systems intervention, such as with schools.

• Overall, Take Two undertook systems intervention, usually in combination with direct intervention with the child or their family/placement, with over two thirds of the client group. For example, in nearly a quarter of the cases, systems intervention occurred with schools.

**Individual intervention with children**

• Individual therapy with children was a frequently reported focus of intervention by Take Two, usually in conjunction with other therapeutic approaches.

• There is more than one individual-focused therapeutic modality used within Take Two. These include play therapy, cognitive-behavioural approaches and behaviour management.

• The majority of children of all ages except infants were engaged in individual therapy, with the greatest number and percentage aged between 9 and 12 years. Infrequent use of individual therapy with infants was consistent with a developmental perspective.

• Although the majority of children living with one or both parents at the time of referral received individual therapy, this was a smaller group compared to children living in out-of-home care.

• Aboriginal children were significantly less likely to receive individual therapy than non-Aboriginal children.

**Intervention with children and their families and carers**

• In some situations family work may require more than one clinician in order to respond to the dynamic and sometimes chaotic interactions within sessions. This could be a factor in why the only significant difference found regarding this type of intervention is that it was more likely to occur in metropolitan compared with rural areas, as these teams have more workers.

• Parent-child intervention and family work in general was more likely when the child was living with one or both parents at the time of referral.

• Although most children were placed in some form of out-of-home care, more children were involved with parent-child therapy (10%) than carer-child therapy (6%). This may reflect the Child Protection case plan.

• Only a small percentage of cases involved therapeutic work with two or more siblings together.

• No sibling interventions were undertaken with adolescents and were more likely to occur with younger children.

• Younger children were significantly more likely to be involved with family-based work than older children.

**Child-focused intervention with parents and carers**

• Nearly a third of interventions were child-focused parent work and similarly nearly a third were child-focused carer work. This higher proportion of parent work than the number of children living with parents possibly reflects that the case plan for many was reunification. These types of interventions were focused on helping the parent or carer understand the child’s experiences and the appropriate nurturing responses.

• Significantly more child-focused parent work occurred in metropolitan areas than rural.

**Intervention with the system**

• Take Two staff journals highlighted the clinicians' awareness of Take Two as part of the service system and the importance of working within this system. The care team function was acknowledged as a cornerstone of systems intervention.

• Take Two intervened at the system level for more than two thirds of clients, including schools.

**Intervention with Child Protection**

• All Take Two cases have some Child Protection involvement, but may vary as to whether Child Protection is the active case manager. Either way Child Protection undertakes the case planning function for these children.

• In addition to the Help Desk and care team functions already described, Take Two has provided consultations, psycho-education, attended court and provided recommendations to Child Protection.

**Intervention with placement services**

• Similarly to Child Protection, systems intervention by Take Two with workers in placement services often entailed psycho-education, care teams and support regarding alternative strategies to respond to the children’s difficult behaviours.

**Intervention with schools**

• For a quarter of the cases Take Two undertook an active role with the child’s school or preschool. This work often entailed psycho-education, advocacy and shared problem-solving.

• Systems intervention with schools was significantly more likely to occur for children living in metropolitan areas than rural areas.

• Intervention with schools was the only difference associated with gender where it occurred significantly more often for male children.

**Interventions by Take Two within Secure Welfare**

• Over two fifths of direct service time by the Secure Welfare position was on assessment of the young person. When adding the time spent in assessment of the young person’s family or broader context this represented half of the Secure Welfare position’s time. Eleven percent of the time was in having meetings with the young person’s family. Eight percent of direct service time is in following-up the young people or their family after they were discharged from Secure Welfare.

• Ten percent of the regional and Aboriginal client group were also admitted to the Secure Welfare Service during Take Two involvement. In these cases, their allocated clinician within Take Two continued their work with the children during their admission.

**Youth Justice**

• Fifteen percent of the Take Two client group aged ten or older were involved with Youth Justice. The largest number were between the ages of 12 and 14 years, although the greatest proportion were those 15 years and older.

• Young people involved with Youth Justice were more likely to be in residential care at time of referral to Take Two and the second highest placement type was living with one or both parents. This finding regarding residential care was similar to that found for those young people involved with Secure Welfare.

**Out-of-home care services**

• A Community Service Organisation-placement service was involved with two thirds of the Take Two client group. Although children in home-based care and residential care services at time of referral were significantly more likely to have a placement service involved, nearly a third of those living at home or in kinship care also had such a service involved. This indicated that they may have been placed in out-of-home care following the referral to Take Two.

**Family services**

• Community Service Organisations also provided family services, such as family support and family preservation services, to over a fifth of children and their families.
• Children under the age of three were significantly more likely to receive a family service than young people fifteen years or older.
• Girls were significantly more likely to be involved with family services than boys.
• Children living with their parent/s at the time of referral to Take Two were significantly more likely to be involved with family services compared to those in home-based or residential care.

Mental health and counselling services
• Mental health services were involved with over a quarter of the Take Two clients, with 14 percent of children who were also clients of CAMHS; 7 percent being clients of another child mental health service, such as a private therapist, and 5 percent being clients of a sexual assault service.
• Adult mental health services were involved with eight percent of Take Two cases. Other types of counselling services were involved with another 15 percent of children or their families.
• CAMHS were more likely to be involved with young people between the ages of 12 and 15 years, and then ages 9 to 12 years.
• Although there was no statistical difference between Aboriginal identity and CAMHS involvement, it was less likely for Aboriginal children to be involved with other counselling services.
• CAMHS were significantly more likely to be involved with boys than girls. CAMHS services were more likely to be involved with children in residential care than those in kinship care. Other mental health services were also more likely to be involved with children living in residential care. This may indicate the higher risk of children in residential care regarding mental health problems.
• In terms of the 16 children involved with Take Two in 2005 who were also involved in a sexual assault service, over two thirds were boys. This was not a statistically significant difference, but given the less frequent reporting of sexual abuse for boys especially in the pre-adolescent/adolescent age groups, it was unexpected.
• Adult mental health services were more likely to be involved with Take Two clients when the child was a girl.
• Adult mental health services were more likely to be involved when the Take Two client was Aboriginal.
• Adult mental health services were more likely to be involved when the child was in residential care. This is in contrast to children who were in kinship care, where none of their families were involved with adult mental health services.

Aboriginal services
• Sixty percent of Aboriginal clients were involved with an Aboriginal service according to Take Two.

Drug and alcohol services
• A small proportion of Take Two clients were involved with drug and alcohol services and an even smaller percentage of their families were recorded as being involved with adult drug and alcohol services. All young people involved with drug and alcohol services were 12 years or older. A large percentage of those young people involved with drug and alcohol services were in residential care at time of referral to Take Two.
• Although the numbers of families reported as being involved with adult drug and alcohol services is small a couple of significant differences were found. These children were more likely to be girls and were more likely to be Aboriginal.

Consultations by Take Two
• In 2004, the number of consultations provided by Take Two was estimated at 388. In 2005 this number rose to 1931. This is nearly a 400 percent increase over these two years.
• An estimate based on a sample of cases is that on average each child may be the subject of two to three consultations.
• The majority of consultations were recorded by the metropolitan teams. A disproportionately high number were recorded by the Secure Welfare and Aboriginal teams.
• The largest proportion of children the subject of consultations were aged between 12 and 15 years of age. There was a very low proportion of consultations regarding children under the age of three years.

Chapter 6: Children’s stories

Children’s presentation
• In the 29 case studies, children’s externalising behaviours were often the focus as those in their lives were feeling overwhelmed and not equipped to deal with their behaviours. The behaviours were often given more weight in referral documents than their experiences of trauma and deprivation.
• Families of the children had complex structures and many had a history of intergenerational abuse and/or trauma.
• Although the case studies were not purposefully selected to show high-risk behaviours, the majority were children with severe behavioural problems including arson, sexual offending, violence, criminal activity, substance abuse, hurting animals and self-harming. Many of these behaviours were reported in relation to young children as well as adolescents.
• Although not as frequently reported many of the children showed developmental, emotional and internalised behaviour difficulties, such as being withdrawn, low self-esteem, no friendships, difficulties in concentration, developmental delays, speech difficulties and lack of trust in others.
• A major issue mentioned for many children was a pervasive sense of shame.
• Many of the children were described as demonstrating personal strengths, such as some capacity to relate to others positively, intelligence and ability to trust a particular person.
• Many of the children had one or more mental health diagnoses.

What the children had experienced
• All of the children had experienced more than one traumatic event. As such they had all experienced cumulative harm through ongoing trauma, deprivation and/or disrupted relationships.
• The experiences of these children can be categorised in two ways. Firstly, there were those children who had experienced identifiable traumatic events, such as abuse, and who may or may not have also experienced a chaotic, neglecting environment. The second group had a known history of chaotic, chronic neglect but their history of other abuse was unknown.
• As with the broader Take Two population, most children experienced multiple types of maltreatment and other harmful experiences. These included emotional abuse, physical abuse, neglect, sexual abuse, exposure to family violence and other violence, exposure to parents with a mental illness and/or parents with substance abuse problems. Many children were accustomed to living in poverty. They had experienced severe loss and grief.
• Positive experiences were also noted for a number of these children, particularly around positive relationships with family, carers or schools.
Take Two interventions

- Assessment and engagement with the children was often intertwined with each other and sometimes with system intervention. These did not occur in a linear fashion.
- Assessment was multi-layered and endeavoured to understand the children in the context of their relationships, past experiences and strengths and difficulties.
- The building of trust and engaging with the child in a therapeutic relationship is an essential component of effective work with the child and in some cases took a long period of time to achieve. In some situations work with other parts of the system, such as the family, carers and/or school, occurred while attempts to gain the child's trust continued. In some cases engagement was a primary goal aiming for a fundamental change in the child's capacity to form trusting relationships. In other situations engagement was seen as a means to achieve other goals with the children, such as their ability to use therapy to work through their experiences of trauma.
- Care teams were a common form of intervention used to enlist the support of key players involved in the child's life and were often seen as a critical part of the strategy upon which other interventions relied.
- The range of interventions undertaken with this client group was diverse and multi-faceted. These included individual child therapy, parent or carer-child therapy, child-focused parent or carer therapy and system intervention.
- Some parts of the Take Two program require different therapeutic approaches such as the role within the Secure Welfare Service and the Aboriginal team. The Take Two Secure Welfare role is always brief due to the short time that the young people are placed in the Secure Welfare Service. The work of the Aboriginal team, whilst sometimes using approaches similar to other teams, is enhanced by enabling Aboriginal children to have access to an Aboriginal worker.

Case closure

- The cessation of work by Take Two is informed by the Take Two intervention plan (assessment, engagement and interventions), the availability of other services to pick up certain functions and the case plan and role of Child Protection. It is a complex decision where timeliness of decision-making and effective communication with the children and their networks are paramount. For example, sometimes improvement in the child's emotional and behavioural symptoms indicates it is an appropriate time to close, whereas in other cases improvement may indicate that further intervention is appropriate to embed the changes.

Outcomes

- Frequently mentioned outcomes by clinicians were strengthening the child's relationship with his or her family and/or carers by strengthening the parent's or carer's ability to understand and respond more effectively to the child; a reduction in the child's emotional and behavioural symptoms; the child's ability to engage in assessment and therapeutic intervention; and changes in how the system responded to the child.
- Examples of the child's behavioural symptoms that were noted to have reduced were self-harming, violence to others, substance abuse, absconding, school refusal, enuresis and encopresis. Re-engaging the child at school, improved impulse control, improved peer relationships, a willingness to talk about his or her feelings, improved sleep patterns, improved cultural connectedness and a stronger sense of family and self-identity were other outcomes described by clinicians.
- Where outcome measures were available, in some cases they supported the perception of the clinicians regarding positive changes having occurred, while in a couple of cases they showed a different picture. When this occurred it appeared to be regarding recent events leading to the child being unsettled or the clinician working more directly with the child on past trauma. This indicates both the need for careful planning around the timing of certain interventions and the reality that a linear process of recovery is not always going to be, in fact may rarely be, the case. It also highlights the importance of not just relying on one mode of feedback regarding outcomes.

Chapter 7: Outcomes - Social Network Maps

- Social Network Maps provide an opportunity for children to describe their perceptions of who is important to them in their life and the quality of these relationships.

Who was listed in their social network

- Children were more likely to list family, friends and household members than neighbours or those they knew through clubs and other organisations. The predominance of family and household members became even greater when children listed the top 15 people in their lives.
- The majority of children listed at least one person in their life they saw daily, but not all.
- The children knew over a third of those listed in their networks for more than five years and under a third were known for less than a year.
- As noted in the literature, age has an influence on how children interact with their social networks, including who, how many and in what circumstances. The younger the child the more likely their social networks are largely determined by their families. Children in transition from Primary to Secondary school are also likely to experience changes in their networks.
- Children in the protection and care system are more likely to have changes in their social networks especially if they have multiple placements, multiple reunification attempts and multiple schools. The average number of placements prior to referral to Take Two for the children completing Social Network Maps was seven with a range from no changes to 18 placements.

Child's households

- The average number of people in the children's households was three people with a range from zero to eight people. Two fifths of those in the household were carers which included parents, foster parents, kinship carers and residential care staff. The next largest group in the children's household were siblings.
- Nearly two-thirds of those in the children's households were described by the children as 'very close'.
- Three fifths of the children described one or more of their carers as 'very close' and 'almost always' emotionally supportive and 'almost always' providing concrete support. The children described parents, kinship carers and foster parents equally in terms of closeness.
- Other household members were less likely to be described as 'very close', or 'almost always' providing emotional or practical support.
- More than half the children knew their carers for less than five years, especially when the carers were foster parents or residential care staff.

Child's family relationships

- Every child included at least one family member in their Social Network Map with the average number of family members listed being six.
- The children listed a range of family relationships in their networks, including those they lived with and those they rarely
saw. In order of frequency they listed their siblings, mothers, grandparents, fathers, aunts or uncles, step-parents and cousins or nephews. This shows both the breadth and scarcity of relationships. For example, although all, except one, of the children had a living mother, a third did not include them as people who were important in their life. Nearly a quarter of the children did not list either parent, all of whom had at least one living parent.

- The absence of fathers for many of these children was particularly marked, especially when considering that the two children whose fathers had died did include them in their network. It would appear that the absence of fathers is an issue from a systems, family and child perspective.

- The most frequently noted family members were siblings, both in terms of how many children listed one or more and in terms of how many were listed by each child. Even so, compared with Child Protection records, most children did not include all their siblings. Siblings were also the family members that children had the most contact with. The Social Network Maps emphasise the importance of siblings which is consistent with findings from other studies.

- As less than a fifth of these children lived with one or more parents, their family was distinct from their household. Even when taking into account those who lived with extended family the majority were cared for by non-family members. Over two fifths of children did not live with any of their siblings.

- Many children described their parents and other family members as ‘close’. Of all family members described as ‘very close’, the most frequently mentioned were siblings, mothers and grandparents. Within family relationships children were most likely to describe aunts and uncles, siblings, grandparents, mothers, fathers or step-fathers as ‘very close’. This illustrates the importance of thinking broadly regarding the importance of family relationships.

- One or more grandparents were mentioned by over half the children as important in their lives.

- Where the child was living appeared to be associated with whom they defined as being in their social network, especially in relation to the presence or absence of family.

- Although children usually perceived family members as ‘very close’ this was not always the case. Closeness was also not always associated with those with whom the child lived.

- When children listed aunts and uncles, siblings and grandparents they were more likely to be described as ‘very close’ compared to other family members such as parents.

- The most disparate type of family relationship in terms of closeness were siblings where children sometimes described one sibling as ‘very close’ and others as ‘not very close’. For example, three children described the sibling they lived with as less close than the ones they did not live with.

**Child's friendships**

- Three quarters of the children listed at least one friend, almost all of whom were a similar age to the children.

- Many of the children appeared equivocal in their descriptions of their friendships, with over half describing at least one friend as ‘very close’. In general the child’s perception of the level of support they received from friends had little association with whether or not the child described the friends as ‘very close’. However, there did appear to be an association between friends being described as ‘not very close’ and those who hardly ever offered practical or emotional support.

- Nearly a third of the children described only friends they had known less than one year and only 15 percent of friends were known for longer than five years. This may be developmentally appropriate for the younger children but is nonetheless of interest.

- Other research has shown that friendships are a resilience factor following an adverse event as long as the children are not separated from their friends as a result of the event.

**Professionals**

- Over two thirds of the children listed at least one professional although most did not list more than two or three. The professionals in order of frequency were Take Two clinicians, Child Protection workers, placement workers and doctors.

- Nearly half the professionals were described as ‘sort of close’ with the smallest number described as ‘very close’.

**Neighbours and local organisations**

- A fifth of the children mentioned someone they knew from a club or organisation such as sports club or church. Even fewer mentioned a neighbour.

**Levels of closeness and different types of support**

- On the whole, children appeared able to make distinctions between who they were closest to and what type of support they received from them. This was seen in relation to household members, family members and teachers.

- Most people listed in children’s Social Network Maps were either described as ‘very close’ (47%) or ‘sort of close’ (34%). This is similar to the average respondent’s feeling ‘very close’ in Tracy’s study of at-risk families.

- More people were perceived by children as ‘hardly ever’ providing concrete or practical support than as providing it. More people were described by children in relatively equal terms across the range from ‘almost always’ to ‘hardly ever’ providing emotional support.

**Level and length of contact**

- On average, children were in contact with 53 percent of the people they listed on a daily basis and 46 percent on a weekly basis.

- The children knew just over a third of the people in their lives.

**Changes in social networks over time**

- In all but two of the ten repeat cases (80%) more people were described as closer in the second or final Social Network Map compared to the first.

- Whilst there appears to be minimal differences between the proportion of people providing emotional and practical support over the two time periods, there does appear to be more people providing information and advice in the second time period.
• Most children had more than half the people whom they placed in their Social Network Map as different over the two time periods. This may reflect a change of who is in their network or their perception of who is important. It is a greater percentage of change in networks than what has been found in adult studies regarding families at risk and so may reflect a developmentally driven change, such as through change in school or a system-driven change, such as change in placement.

Chapter 8: Outcomes - Emotional and behavioural symptoms

Areas of problems according to the SDQ

• Over four fifths of young people and an even higher proportion of parents, carers and teachers reported the young people's emotional and behavioural symptoms as in the borderline or clinical range for at least one of the areas in the SDQ; namely conduct problems, emotional problems, hyperactivity, peer relationship problems and problems in prosocial behaviour. Over half of the children and a majority of all other types of respondents reported that the children had two or more difficulties in the borderline or clinical range.

• Young people reported themselves in the borderline or clinical range most often for conduct problems followed by hyperactivity, both of which were nearly two thirds of the young people.

• The next highest group of respondents in terms of reporting concerns were teachers. They reported the children in the borderline or clinical range most often for conduct problems, hyperactivity and an absence of prosocial skills. All of these scales were reported close to or higher for two thirds of the children. Over half the teachers reported children in the borderline or clinical range for peer problems.

• The respondents who reported the second highest proportion of concerns were parents. Parents reported children in the borderline or clinical range most often for conduct problems, peer problems, emotional problems and hyperactivity. These were all near or higher than two thirds of the children.

• The respondents who reported the highest proportion of concerns were carers. They reported the children in the borderline or clinical range most often for conduct problems, peer problems, hyperactivity and emotional problems. All of these areas of difficulties were more than half, with all except emotional problems being more than two thirds.

• When comparing across respondent groups, young people significantly less frequently reported that they were in the clinical range on most scales compared to parents, carers and/or teachers. Young people and teachers were significantly less likely to report in the borderline or clinical range for emotional symptoms compared to parents and carers. Young people were significantly less likely to report conduct problems compared with carers. Peer problems were identified significantly more often among parents and carers than by the young people. Young people were significantly less likely to report concerns in prosocial behaviours compared with teachers.

Total difficulties scale

• In terms of the overall difficulties, over half of each respondent group reported in the borderline or clinical range, with the highest groups being carers and parents (both of whom were over four fifths), then teachers and the young people themselves.

• A comparison across groups shows that parents, carers and teachers were significantly more likely to report the children in the borderline or clinical range in the total difficulties than young people.

• Take Two clients are presenting with difficulties in multiple settings; namely in their home, placement and school.

Prosocial scale

• In relation to the questions regarding the children's prosocial behaviours, teachers were the group most likely to report children in the borderline or clinical range. They reported nearly two thirds of the children as having less prosocial behaviours compared to the general population. This was followed by carers, parents and young people.

Overall difficulties and chronicity of problems

• More than four fifths of all type of respondents reported that the children had definite or severe difficulties. Teachers most frequently reported difficulties, followed closely by carers, both of whom reported more than three quarters of the children as having difficulties. Two thirds of parents and nearly half the young people reported these difficulties.

• The majority of parents, young people, carers and teachers, in that order, reported that the children had experienced their problems for over a year. There was some difference associated with type of respondent, and one hypothesis for this difference is that some of the teachers and carers did not know the child for over a year.

Impact on child's daily life

• Two thirds of the young people who reported difficulties described these difficulties as impacting on their lives in the borderline or clinical range. Four fifths of teachers, parents and carers in increasing numbers also reported this impact on the children’s lives.

• Almost half the young people reported that their difficulties made it a ‘medium’ or ‘great deal’ harder for those around them. This finding was higher for teachers, carers and parents with parents commenting in two thirds of the cases that the child’s difficulties made life difficult for others.

Comparison with other studies

• Although the frequency of problems was generally less in this study compared to those reported in a study regarding CAMHS clients, there were similar patterns of concerns, particularly for conduct problems. Teachers reported more frequent concerns in the Take Two study than in CAMHS study.

• When comparing the results from the Take Two study with a study regarding children in out-of-home care in the UK there was a very similar pattern and frequency of concerns regarding the proportion of children in the clinical range.

Repeat measures - Analysis of changes in emotional and behavioural difficulties over time

• Repeat SDQ measures indicated trends towards positive change for children in a number of areas, although the number of repeat measures is too small to be conclusive at this time.

• Young people, parents, carers and teachers noted reduction in symptoms over the two time periods, although most of these reductions were not statistically significant.

• Young people reported a reduction in the borderline or clinical range for all areas of difficulty, except peer problems. The reductions were not statistically significant. There was no change noted in prosocial behaviour.

• Parents noted a reduction in the percentage of children who were in the borderline or clinical range for all areas of difficulty, with no change in prosocial behaviour. These improvements were not statistically significant.

• Carers noted a reduction in the percentage of children who were in the borderline or clinical range for all areas of difficulty and prosocial behaviours, except for emotional symptoms which rose. A significant change was noted in the reduction of hyperactivity.
• Teachers showed a more varied pattern with most scales reducing, but a couple (emotional and peer problems) increasing. None of these changes were significant.

• When comparing the mean scores at the time of the first SDQ to the last SDQ, the only significant improvements noted were by carers in relation to the children’s conduct problems, hyperactivity and total difficulties score.

• All respondent types showed a reduction in the percentage in the borderline and clinical range on the total difficulties scores over the two time periods, although none of these were significant.

• Three quarters of young people reported that their problems were better since coming to Take Two, while nearly two thirds found Take Two had been helpful in other ways, such as providing information or making problems more bearable.

• The majority of teachers, carers and parents reported that the child’s problems had improved since Take Two involvement and that Take Two had been helpful in other ways.

• There was a strong positive correlation between how the respondents reported on whether the child’s problems improved and whether the Take Two service was helpful in other ways. This correlation was strongest for the young people themselves and was not present for teachers.

Chapter 9: Outcomes - Trauma symptoms

Symptoms related to trauma at baseline

• Over two fifths of the children had at least one area of trauma-related concerns in the clinically elevated range, indicating that they were showing more symptoms than what would be expected in the general population. The majority of these had two or more areas of concern in the clinical range.

• Children who were clients of a rural team were more likely to have one or more scales indicating trauma-related symptoms in the clinical range compared to clients of metropolitan teams.

• The most frequently elevated scale was sexual concerns where a fifth of the children were in the clinical range. Most of these elevated scores were in the sexual preoccupation area. In order of frequency this was followed by depression, dissociation, anger, specific posttraumatic stress symptoms and anxiety.

• The only statistically significant difference regarding the trauma-related areas of concern and the child’s demographics were in relation to sexual concerns. Older children were significantly more likely to be in the clinical range than children aged 12 years or younger, especially in relation to sexual preoccupation. This was consistent with the findings based on the Harm Consequences Assessment regarding sexualised behaviours. Secure Welfare clients were significantly more likely than other teams to have clients in the clinical range regarding sexual concerns.

• Although a reasonable proportion of Take Two clients presented with one or more clinical scores, this was lower than what would have been expected given their known trauma histories. The number of scales scored at the clinical level slightly increase when only analysing the baseline data collected in the first six months of Take Two involvement. This may indicate that reduction of symptoms may have already occurred for some of the children who completed their first measure later than the initial six-month period. Another hypothesis is that traumatised children are likely to underreport symptoms, as has been reported elsewhere. A third hypothesis is that this may accurately represent their traumatisation, although this would be inconsistent with the other data.

Repeat measures - What changes have occurred

• During Take Two’s involvement, there was a reduction in trauma symptoms in every scale, with significant changes found in reduction of posttraumatic stress symptoms and anxiety. Scales close to significance in improvement over time were a decrease in anger symptoms and depression symptoms.

• When comparing the percentage of children who scored in the clinical range over time, there was a reduction of those in the clinical range for every area of concern. The only significant change was noted regarding depression.

Chapter 10: Outcomes - Client and other stakeholder feedback

Their experience with Take Two

• Nearly nine tenths of all types of respondents rated the Take Two service as excellent or good. Four fifths of children, parents and carers rated the service highly with an even higher positive rating from workers across all fields.

• Nearly nine tenths of all stakeholder groups were satisfied with the Take Two service. When considered separately, there was a higher level of agreement with statements regarding the Take Two clinician being understanding, liking the service received from Take Two and Take Two respecting the child’s culture or spiritual beliefs.

• Nearly all carers and workers and a high proportion of parents and children agreed that Take Two respected the child’s culture or spiritual beliefs. No respondent disagreed with the statement so the difference was that more children and to a lesser extent parents were undecided.

• One hundred percent of the surveys completed about Aboriginal children agreed that Take Two respected the child’s culture or spiritual beliefs.

• Carers were the highest group in agreement with the statement regarding liking the help Take Two gave them, closely followed by workers. Workers, carers and children were all equally high in agreement that the people at Take Two were understanding, with slightly fewer parents, albeit still a substantial majority.

• In general there were no significant differences in responses depending on type of worker regarding the questions pertaining to level of satisfaction.

• More than three quarters agreed that Take Two had helped the children with their life. This question had the most variation across stakeholder groups. Workers were the most likely to agree followed by children and carers. Although more than half agreed, parents were less likely to agree with this statement compared to other stakeholders. Most of those who did not agree were undecided.

• A significant association was found between the longer Take Two was involved with the child and the greater likelihood the respondents would agree that Take Two had helped the child with his or her life.

• Overall in relation to the questions pertaining to level of satisfaction all stakeholder groups recorded high levels of agreement, with workers being the highest, followed by carers, children and parents.

Perception of outcomes

• The outcome specific questions were predominantly positive in that most noted improvement. However, they were not as high in percentage as questions relating to satisfaction. Though satisfaction and outcome-related questions were strongly correlated, other studies have also found a similar pattern of higher satisfaction levels compared to perception of change.
Over four fifths of children agreed that positive changes had occurred. They were the highest group of respondents regarding change.

Although not significant, more children and workers agreed that positive change had occurred compared to parents and carers. Parents noted change less often compared to other respondents, except in relation to whether changes had occurred within the family. Within the workers category, there were no statistical differences although teachers were more likely to agree, followed by Child Protection workers.

Two thirds of Child Protection workers and teachers agreed that the child was doing better at school compared to just over half of workers from Community Service Organisations.

On average for the questions relating to outcomes, four fifths of stakeholders agreed that the child had made positive gains since Take Two’s involvement. The highest group were the children who agreed that they were happier. The next highest response was from other respondents agreeing the child was better able to handle daily life, followed closely by those who agreed that the child’s problems had improved. The question showing least agreement, though still more than half, was regarding whether or not the child is better able to cope when things went wrong.

Although not statistically significant there were common patterns found between the greater the perception of positive change and the longer Take Two was involved.

There were large correlations between a number of items regarding satisfaction and outcomes. Examples of large correlations included the respondents liking the help that Take Two provided and Take Two staff being understanding; Take Two’s respect for culture or spiritual beliefs with the child being better able to handle daily life and Take Two helping the child with his or her life. There was a moderate correlation between the mean score of the items relating to satisfaction with the items relating to outcomes.

Comments in surveys

Nearly two thirds of the children had one or more statements regarding what was helpful about Take Two. In particular they found talking and being helped with problems as the most helpful elements to Take Two.

Over half the parents had one or more statements regarding what was helpful. A third of parents commented on the direct support they received from Take Two.

Over four fifths of carers wrote one or more statements regarding what they found helpful, with a fifth commenting on the direct support they received from Take Two. The next most frequent theme was the knowledge and level of understanding of the Take Two clinicians. They also valued the child being seen in therapy and the child’s relationship with the clinician.

Over two thirds of workers made one or more statements regarding what they found helpful about Take Two. These included Take Two’s facilitation of communication across services and with families and carers, the role of care teams and collaborative practice and Take Two’s role in supporting carers. There was also comment on Take Two’s direct work with the child.

A smaller proportion of respondents commented on what could be improved with Take Two compared to what they found helpful.

A quarter of the children made one or more comments regarding improvements which included more direct help, more activities and one comment regarding more help for their family.

Just over half the parents made a comment regarding what could be improved in the Take Two program. A quarter of the comments suggested Take Two could provide a more practical approach, work directly with the family or more work with the child. A couple of comments related to improved feedback and others related to the delay in being accepted into the program or requesting Take Two stay involved for longer.

Just over half of the carers had a comment regarding possible improvements to the Take Two service. The most frequent theme was improved communication and feedback to the carers, followed by broader systemic change beyond Take Two’s role and practical assistance to carers. Other comments related to insufficient service to meet demand.

Over half of the workers had at least one suggestion regarding improvement for Take Two, the most common of which was the insufficient capacity of the service to meet demand. Comments were also made regarding the need for broader systemic changes. Some comments also noted the possibility of Take Two working differently with the children and their networks.

**Secure Welfare**

In terms of the surveys, no stakeholders disagreed with either satisfaction with the Take Two role in the Secure Welfare Service or particular processes undertaken by that role. Ninety-five percent graded the service as excellent or good.

The focus group of Secure Welfare Service staff showed a similar high regard for the role and performance of Take Two within the Secure Welfare Service.

Some focus group participants said they were unclear of the differences between the role of Take Two and CAMHS. However, other staff understood the CAMHS focus on mental health and indicated the two programs worked collaboratively for the child. It was suggested that the relationship with CAMHS services had improved as the Take Two clinician could clarify the role of CAMHS and avoid unrealistic expectations of that service.

The role of Take Two in providing direct service to clients in the Secure Welfare Service through psychological assessments was valued.

A key feature of the Take Two service valued in the Secure Welfare Service was the accessibility of the service. Secure Welfare Service staff appreciated the willingness of Take Two in Secure Welfare to accept referrals.

Some Secure Welfare Service staff had a limited understanding of the role of Regional Take Two teams, but had some knowledge of the Aboriginal team.

Recommendations for change in the Take Two service from both the surveys and the focus group were a request for more resources, such as additional Take Two staff located within the Secure Welfare Service and greater access to the Aboriginal Take Two team. An increase in funding from DHS for Take Two’s role within the Secure Welfare Service occurred after the surveys and focus group had occurred.

**Chapter 11: Outcomes - Take Two perspectives on outcomes**

**Trauma and stability of placement**

Nearly three fifths of the children were described by Take Two clinicians as having high trauma or deprivation and low stability of placement. This indicates the high levels of vulnerability in terms of the children’s past experiences and high levels of risk for future harm. The trauma and deprivation history indicate the need for slow, consistent approaches while the lack of access to a consistent carer for many highlights the dilemmas in providing such intervention.
• Nearly a fifth of the children had complex trauma presentations, but with a stable placement. This enables different types of therapeutic intervention to occur that can enlist the involvement of the parent or carer in the child’s process of recovery. Complex trauma histories usually require a ‘slow but sure’ approach to intervention. A smaller proportion had an acute but not complex presentation of trauma and high stability of placement. Tailored approaches specific to the trauma events can usually be utilised in these situations.

• Most of the children display levels of traumaticisation although may not meet the criteria for Posttraumatic Stress Disorder. This is consistent with the literature that argues that the diagnostic classification was written in relation to adults and so is not always an appropriate fit for children.

• The only significant difference between trauma presentation and placement stability was in relation to whether or not the children were Aboriginal. Aboriginal children were significantly more likely to have been described as having a chronic trauma presentation and not being in a stable placement at the time of initial assessment.

Engagement with children
• According to clinicians, Take Two effectively engaged with over four fifths of the clients. Of those children not considered to have engaged, over half were still open cases. The only significant difference found regarding client demographics and level of engagement is that for the small number who were not engaged, more were likely to be adolescents.

• For the 34 children not effectively engaged, clinicians rated over half as having made good or fair progress and that problems had improved for nearly a third.

• The largest correlations between engagement and other questions on the survey was how they rated the child’s overall progress, such as gender or Aboriginal identity. Nor were there any demographic differences associated with overall progress, such as gender or Aboriginal identity. Nor were there any significant difference based on length of Take Two involvement.

Overall client progress during Take Two involvement
• Clinicians rated over half the children’s overall progress as good or excellent.

• There were significantly moderate to strong correlations between the children’s overall progress and most questions pertaining to specific outcomes.

• Children aged between three and nine years were significantly more likely to show overall progress than other age groups. There were no other demographic differences associated with overall progress, such as gender or Aboriginal identity. Nor was there any significant difference based on length of Take Two involvement.

Child-related changes
• The mean score across the client group for client-related improvements indicated positive changes.

• Clinicians rated over two thirds of the children having improved in their problems. This was strongly correlated with other child-related questions and the parents, carers and school having an improved capacity to meet the children’s needs.

• Two thirds of the children were considered to be able to manage their daily life in a better way since Take Two involvement. This was more likely to occur for children aged under 12 years of age.

• Just over half of the children were considered to have improved relationships with family members.

• Nearly three quarters of the children in care had an improved relationship with their carers since Take Two involvement. The only significant difference was that this was most likely to occur for children aged under 12 years of age.

• Nearly two thirds of the children had improved relationships with peers and others since their involvement with Take Two. This was significantly more likely to occur for children aged between 3 and 12 years.

• Two thirds of the children who attended school or preschool showed improvement in their functioning at school. This was significantly more likely for children aged between three and nine years.

• Over half the children were more able to cope with adversity than previous to Take Two involvement. This was significantly less likely for young people aged 15 years or older.

• The questions relating to the children having improved relationships with significant people showed positive change for over half, especially in relation to carers. This is particularly noteworthy given the prevalence of attachment difficulties and general relationship problems in this client group.

Parent-related changes
• Overall, clinicians reported there was little improvement in parent’s capacity to understand or meet the emotional needs of their children. The only significant difference found was that improvement in both understanding and meeting the children’s needs was more likely to be noted for clients in metropolitan areas than rural areas.

• Over a third of the parents had improvement in understanding the children’s needs and less than a third showed improvement in their capacity to meet these needs. This may reflect the chronicity of problems experienced by many of these parents and that in some situations their improved understanding was not yet translated into action.

Carer-related changes
• Clinicians reported positive changes for carers. Over four fifths of the carers were described as having improved understanding of children’s needs. Three quarters of the carers also showed improved capacity to meet these needs. Although these questions were strongly correlated, some differences were noted indicating that improved understanding did not always equate to improved capacity to meet the children’s needs.

School-related changes
• Improvements were noted in the school’s capacity to understand and to respond to most of the children’s needs.

• Clinicians reported positive change in four fifths of the cases regarding the schools improving in understanding the children’s needs and over three quarters in meeting the needs of the children.

• The questions relating to change in school were the most closely correlated indicating that when schools showed change in understanding the children’s needs they were more likely to demonstrate this in improved capacity to meet the children’s needs, although there were still some exceptions.

• Overall the system-related questions were rated as showing positive changes for most children.

• Although increased understanding by the system was correlated with increased capacity to meet the child’s needs there were a number of situations where one did not lead to the other.