



Social Policy Research Centre

Never Stand Still

Faculty of Arts and Social Sciences

Preventing Child Abuse and Neglect Through a Common Approach to Assessment, Referral and Support: Evaluating the Trial (Stage 2)

Final Research Report Prepared for the Australian Research Alliance for Children and Youth

Social Policy Research Centre

**November 2012
SPRC Report 7/13**

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ISSN: 1446-4179

ISBN: 978-0-7334-3331-3

Published:

The views expressed in this publication do not represent any official position on the part of the Social Policy Research Centre, but the views of the individual authors.

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Suggested Citation

Hilferty, F., Newton, B.J. and Katz, I. (2012). Preventing child abuse and neglect through a Common Approach to Assessment, Referral and Support: Evaluating the trial (Stage 2). Final Report, SPRC Report 7/13, prepared for the Australian Research Alliance for Children and Youth.

Acknowledgements

The research team would like to acknowledge and thank all those who participated in, and assisted with this research project. We especially thank practitioners for giving up their time to take part in this evaluation. Many thanks are also due to the trial site facilitators for their assistance: Linda Brown, Shelley Wormald, Julie Leete, Jeremy Davidson-Tear, Bev O'Brien, Amanda Bedford and Melanie Hansen. Finally, we would like to thank Amarylise Bessy, Senior Research Manager at ARACY and to Stacey Fox, ARACY project officer.

This research was commissioned by the Australian Research Alliance for Children and Youth (ARACY). The opinions, comments and/or analyses contained in this document are those of the authors and do not represent the views of the Social Policy Research Centre or ARACY.

Abbreviations

ARACY	Australian Research Alliance for Children and Youth
CAARS	Common Approach to Assessment, Referral and Support
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
GLCH	Gippsland Lakes Community Health
GP	General Practice
SPRC	Social Policy Research Centre
UNSW	University of New South Wales

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Executive Summary

This report presents the findings of a formative evaluation of a trial of the Common Approach to Assessment, Referral and Support (CAARS). The Australian Research Alliance for Children and Youth (ARACY) commissioned researchers at the Social Policy Research Centre (SPRC) at the University of New South Wales (UNSW) to undertake the evaluation in April 2011. An interim report on the evaluation was provided to ARACY in December 2011. SPRC interim evaluation report is included as an appendix in the interim project report accessible on ARACY's website: <http://www.aracy.org.au/cmsimages/file/ARACY%20CAARS%20II%20final%20interim%20report.PDF>

CAARS is an innovative tool that facilitates conversations between a wide range of practitioners and client children and families. The aim of CAARS is to help universal practitioners identify early signs of need in clients, and provide appropriate forms of support. The development of CAARS was funded by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). CAARS is identified as a National Priority Project within the National Framework for Protecting Australia's Children (Commonwealth of Australia, 2009). This Framework promotes child protection as 'everyone's responsibility' and CAARS attempts to achieve this by ensuring that universal practitioners who come into daily contact with children and families, know how to engage families in conversations that assist in the early identification of problems and the provision of support.

Given the formative nature of the evaluation, the focus has been on highlighting lessons from the trial to further develop the tool and improve implementation. The key objectives of the evaluation are to:

1. Examine the appropriateness of CAARS in different contexts and with different client groups;
2. Examine how CAARS impacts on the working practices of practitioners who use the tool;
3. Examine the impact of CAARS on interagency collaboration in primary prevention;
4. Develop a better understanding of how families engage with CAARS; and
5. Provide insight into the process of implementation of CAARS in specific geographic locations and how this is likely to impact on any larger rollout of CAARS.

The evaluation draws upon three key sources of data. These are:

1. Monthly site progress reports;
2. Observational data and recorded notes;

3. Interviews conducted with site facilitators, practitioners and ARACY staff (n=47).

Trial sites

CAARS was trialled in four diverse sites around Australia:

1. Interrelate, Lismore (NSW);
2. Northern Connections, Adelaide (SA);
3. Gippsland Lakes Community Health (GLCH) (VIC); and
4. Rockingham Kwinana Division of General Practice (WA).

The sites are identified and structural features described throughout the report because it is important to know how the context of site affects implementation.

Evaluation findings

The evaluation highlighted a number of key findings and these are summarised below:

- The evaluation highlights a variable picture of implementation – much of which can be attributed to key differences in site structures and services. Whilst it is challenging to draw implementation findings from such diverse settings, it is clear that CAARS was most successful in the site providing (secondary) child and family services and comprising an existing organisational structure to support service delivery, and tool promotion and usage. Implementation success also depends upon visible, high-level support for CAARS by management.
- Despite showing great flexibility in use, CAARS was most frequently used as an instrument for initial assessment. Some practitioners, particularly those in healthcare settings, viewed CAARS as duplicating assessment practice, however, others viewed CAARS as enhancing practice.
- A broad range of universal and secondary service practitioners were trained in the CAARS approach and how to use the materials. CAARS was most frequently used by secondary service practitioners who felt competent in engaging families in conversations to identify support needs. Many universal service practitioners displayed a reluctance to embrace an expanded role in child protection and wellbeing. Some reasons suggested for this include anxiety about their level of competence, and concern about what to do if a problem is identified and appropriate services are not available.
- The most popular CAARS materials during the trial were the wheel and the questionnaires. Recommended changes to the suite of materials are outlined in the final section of this report. In particular, CAARS

needs to be adapted to meet the needs of Aboriginal and CALD people, and perhaps those with limited literacy.

- To sustain CAARS use amongst practitioners, there is a clear need for ongoing training and support. An intensive training model comprising follow up shortly after initiation and ongoing support through mentoring and collegial discussion appeared the most effective. Findings indicate that universal practitioners in particular require training not just in how to use the CAARS materials, but also in skills that will build their capacity to engage families and provide appropriate supports.
- There is very little evidence to show that CAARS has been used to facilitate information sharing across different practitioner groups, nor had made any impact on collaborative working across services and agencies.
- There is no evidence of CAARS promoting a common language for child wellbeing amongst universal practitioners.
- A broader rollout of CAARS should target universal service settings rather than geographic sites determined by levels of disadvantage to ensure that implementation aligns better with early intervention principles and the original aim of promoting child protection as a collective responsibility.

The evaluation shows generally positive results in relation to short term project outcomes. However, as yet, there is limited evidence of progression toward long term outcomes (increased collaboration and use of a common language). More work needs to be done to transform the organisational and professional cultures of practitioners, services and sectors who do not view child protection as their concern. The successful use of CAARS by universal practitioners to identify early need has not been established by the trial. It is likely that this could be achieved by a longer and broader rollout targeting universal services.

1 Introduction

This is the final report of the formative evaluation of the Common Approach to Assessment, Referral and Support (hereafter referred to as CAARS). The evaluation of CAARS was commissioned by the Australian Research Alliance for Children and Youth (ARACY), and undertaken by researchers at the Social Policy Research Centre (SPRC) at the University of New South Wales (UNSW). The evaluation began in April 2011. SPRC's interim evaluation report is included as an appendix in the interim report from ARACY to FaHCSIA. This report is accessible at <http://www.aracy.org.au/cmsimages/file/ARACY%20CAARS%20II%20final%20interim%20report.PDF>

This section provides an overview of the background to this project including a description of the development of CAARS, and an outline of the aims and scope of the evaluation.

1.1 Project background

CAARS is a set of tools designed to enhance the capacity of universal service providers¹ to engage with children, young people and families through conversations that facilitate identification of early need and the provision of support. A key goal of CAARS is to challenge the prevailing culture which sees child protection as the sole responsibility of statutory authorities and non-government community service organisations. Consistent with the National Framework for Protecting Australia's Children (Commonwealth of Australia, 2009), CAARS promotes child wellbeing and protection as 'everyone's responsibility' – particularly universal practitioners who are well placed to engage children and families in conversations to identify need and provide some forms of support if required.

The significant role of universal practitioners such as doctors, teachers and early childhood workers, in identifying and responding to need in children is becoming increasingly clear. There is now a great deal of empirical evidence that universal practitioners are often the ones who have most contact with vulnerable families and are trusted and accepted by these families. These workers are therefore in a good position to be able to identify problems and to help families address these issues before they become crises or escalate into the child protection, mental health or other tertiary service systems. The development of tools such as CAARS and the Common Assessment Framework in England highlight an increasing pressure on universal service practitioners to embrace an expanded and central role in child protection.

It has been found in UK studies of serious child abuse that most children who die from abuse or neglect or are seriously injured are not child protection cases but rather are children known to have additional needs and are

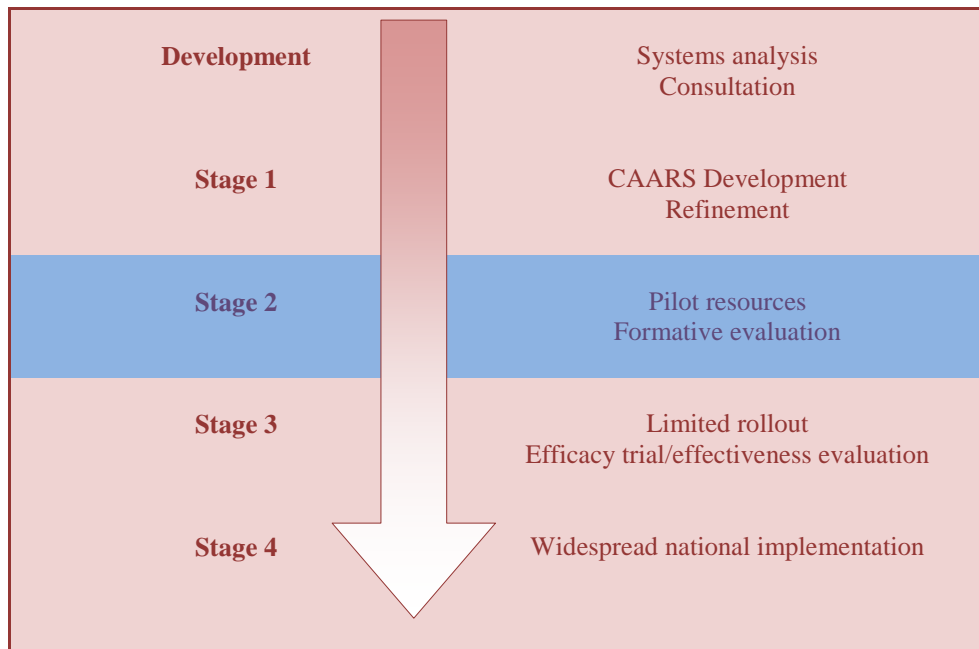
¹ Universal services are available to everyone and accessed routinely by large groups of the population. These services include antenatal services, maternal and child health services, childcare, preschool, and schools.

connected to universal services (such as schools and local doctors) (Brandon et al, 2010; Brandon et al, 2006).

Australia has a well-developed infrastructure of legislation, policy and support to help children at risk of child abuse and neglect. Nevertheless CAARS is the only tool to support universal practitioners in promoting the safety and wellbeing of children and young people. The significance of CAARS is attested through its funding as a National Priority Project within the National Framework for Protecting Australia's Children, 2009-2020 (Commonwealth of Australia, 2009). Within the National Framework, CAARS is positioned as a key initiative helping to achieve specific policy outcomes: improving information sharing between government agencies and non-government service provider organisations; and increasing the capability of practitioners working with children and families to identify need and respond appropriately.

The development of CAARS was funded by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). As shown in Figure 1 below, CAARS development has comprised multiple stages, beginning with the establishment of an expert taskforce to examine tool options², and progressing to tool development, refinement and trial implementation. Stages yet to be implemented include a broader rollout of the tool and an outcomes evaluation, with national implementation proposed as the final goal.

Figure 1: Stages of CAARS Development



² The Common Approach to Assessment, Referral and Support (CAARS) Ministerial Taskforce was established in April 2009 to develop options for a national, cross-sector approach to identifying and responding to the needs of vulnerable children.

1.2 Project aims and scope

This report presents the findings of a research project undertaken to evaluate Stage 2 (see Figure 1) – the piloting of CAARS in four sites around Australia. The evaluation is not summative in nature because the implementation and assessment of CAARS is likely to be ongoing.

The purpose of the Stage 2 evaluation is to draw upon lessons from trialling CAARS to further refine the materials and provide recommendations to enhance practitioners' usage and client engagement. This focus on development and improvement has required SPRC researchers to work closely with project personnel within ARACY and the pilot sites (hereafter referred to as site facilitators or site champions) to ensure that the evaluation represents the best value for available resources and meets the needs of key stakeholders. Following submission of the evaluation interim report in December 2011, it was decided that this goal would best be achieved through SPRC focusing resources and attention on the views of practitioners.

The objectives of the evaluation are to:

1. Examine the appropriateness of CAARS in different contexts and with different client groups;
2. Examine how CAARS impacts on the working practices of practitioners who use the tool;
3. Examine the impact of CAARS on interagency collaboration in primary prevention;
4. Develop a better understanding of how families engage with CAARS; and
5. Provide insight into the process of implementation of CAARS in specific geographic locations and how this is likely to impact on any larger rollout of CAARS.

This report addresses these objectives through multiple data sources, however the main focus is on the views of practitioners that have chosen to use or not use CAARS.

1.3 Report Structure

This report presents the findings of the evaluation of the CAARS trial. This first section provides a brief overview of the history of the project, and its aims and scope. Section 2 describes the methodology employed to undertake the evaluation, the data sources drawn upon, and the method of analysis applied to each data source. Section 2 presents contextual information to facilitate understanding of CAARS implementation in the four trial sites. Section 3 presents the core findings of the evaluation with an assessment of CAARS undertaken by examining the appropriateness of the instruments, its impact on practitioners and families, and a discussion of how practitioners engaged with CAARS. Section 5 discusses the implications of the findings for any

broader implementation of CAARS. Section 6 presents a conclusion to the evaluation, with the report concluding with a recommendations section (section 7).

2 Project Methodology

This section provides an overview of the methodology used to evaluate CAARS. The evaluation has been formative in nature, and we outline the features of this methodology below.

2.1 A Formative Evaluation

The evaluation of the trial of CAARS was formative in nature. As with many methodological approaches there is no single definition of a formative evaluation, but the primary purpose of a formative evaluation is to improve the quality of the program or intervention that is being developed or trialled so that it is more likely that it will achieve the objectives for which it was designed (Beyer, 1995). This methodological approach has been used extensively by education researchers to examine pedagogical practices and students' learning experiences.

The application of a formative approach presented challenges in this project as it relies upon ongoing participation by key stakeholders and hence may involve a greater participatory burden than traditional summative evaluation methodologies. Indeed, it was evident towards the end of this evaluation that some site champions were fatigued by the trial and evaluation process. The shift in focus towards the enhancement of CAARS through a deep understanding of its use and usefulness within specific contexts required an adjustment in expectations and operations. In particular, the value of qualitative data became clear to an evaluation which focuses on understanding and assessment rather than measurement. Formative evaluations seek to enhance a program or intervention by examining its implementation within specific contexts. A formative evaluation was most appropriate for this stage of the CAARS trial as this method enables evaluators to respond to the dynamic context of implementation and helps to generate ideas about how the CAARS materials and conversations could be improved.

There is limited research on formative evaluation practices as they relate to child protection assessment tools. To this end, we adopted methods to meet the demands of this specific project. The method of evaluation adopted for this study was informed by the three concepts embedded in the evaluation objectives: appropriateness, impact and engagement. The usefulness of these concepts is demonstrated in section 4 which highlight their utility in analysing the collected data and evaluating CAARS.

2.2 Data Sources

The researchers drew upon multiple data sources to evaluate the CAARS trial. Data sources comprised:

- Monthly site reports submitted online to ARACY's CAARS Champions Community;
- Observational data and recorded notes collected during teleconferences and other meetings; and

- Interviews with site facilitators, practitioners using and not using the tools, and key project staff from ARACY (n=47).

Interviews for this final phase of the evaluation were mainly undertaken with practitioners; including those who had and had not used the CAARS tools. A non-random sample of practitioners voluntarily participated in interviews. A semi-structured interview schedule was created to guide the interviews with practitioners (see Appendix B). Interviews generally lasted between 20 and 60 minutes, and were conducted either over the telephone or face-to-face. With the permission of participants, all interviews were tape-recorded and later transcribed for analysis.

The sample sizes for data collection in both rounds of this evaluation are shown in table 1 below.

Table 1: Sample size

	Round 1				Round 2				Grand total	
	Practitioners using CAARS	Practitioners not using CAARS	Site facilitators	Total round 1	Practitioners using CAARS	Practitioners not using CAARS	Site facilitators	Total round 2		
Adelaide	0	0	2	2	6	2	1	9	11	
Gippsland	1	0	2	3	5	0	0	5	8	
Lismore	1	0	1	2	7	4	1*	12	14	
Rockingham/ Kwinana	0	0	1	1	7	2	1	10	11	
ARACY personnel	1			1	2			2	3	
Grand total					9				38	47

*Indicates site facilitator was also interviewed from a practitioner perspective

2.3 Data Analysis

Interview transcriptions were analysed with the assistance of NVivo 9, a qualitative data analysis software package. To begin, a 'CAARS' project was created in NVivo and all transcripts and monthly site reports were imported into the project folder. A coding framework was then drafted and revised following hand coding of two hard-copy transcripts (see Appendix C). The framework was then created within NVivo using five core 'tree nodes' (CAARS materials, CAARS training, CAARS trial, general feedback, organisation and site) and six 'free nodes' to collect other data (case studies, changes in practice from CAARS, use of CAARS beyond trial, miscellaneous, non-users, role of ARACY). All interviews and monthly site reports were coded using this node structure. Each node represents a conceptual category, used to integrate data into themes. Coding therefore enables data to be managed

easily by reducing it and linking data across sources to related themes. Following this process, 'text search', 'word frequency' and 'coding' queries were run across different sets of data (round 1 interviews, round 2 interviews, monthly reports) to identify important pieces. Through this intensive process of searching through data and writing up results, key findings emerged and are presented throughout this report.

2.4 Limitations

It is important to interpret the findings presented throughout this report in the context of the objectives of the formative evaluation. Formative evaluations seek to enhance a program or intervention by examining its implementation within a specific context. A formative evaluation is most appropriate for the CAARS trial as it enables responsiveness to the dynamic context of implementation and helps to generate ideas about how the CAARS materials and conversations could be implemented better. One limitation to adopting this (or any qualitative) approach is that while the findings are reliable they are not generalisable in the statistical sense.

Further, as shown in Figure 1 (Section 1), a broader rollout and outcomes focused evaluation is planned to follow the small scale trial evaluated here. This evaluation has shown, however, that any evaluation of CAARS which focuses on child and family wellbeing would be extremely difficult to conduct in an academically rigorous way. CAARS is not an intervention program in itself and is most likely to be used with families accessing a number of child and family support services. It would be extremely difficult to establish a benchmark with families from which to measure any improvement as a result of engaging in a CAARS conversation, particularly since the families are very diverse and children range in age from birth until adolescence; establishing outcome measures for this diversity would be extremely challenging. Because of this difficulty, we suggest an alternative methodology in the final section of this report.

2.5 Project Ethics

Ethical approval to undertake this study was sought from the University of New South Wales' Human Research Ethics Committee (HREC). Following requests for additional information and clarification from the HREC on two separate occasions, approval was granted on 31st October (HREC Reference Number 11319). See Appendix A for approval notification.

3 The implementation of CAARS

This section reports data about the implementation of CAARS by different practitioner groups. The aim is to contextualise the data presented as the different site features have impacted significantly on outcomes.

As detailed in section 2, interviews were conducted with a range of different practitioners across the four sites (n=44). We interviewed those that had used CAARS and those that had been trained but had chosen not to use the materials in their daily practice.

3.1 Trial sites

CAARS has been trialled at four diverse sites around Australia: Interrelate Lismore (NSW); Northern Connections (SA); Gippsland Lakes Community Health (VIC); and Rockingham Kwinana Division of General Practice (WA). The sites are named here and throughout the report because an examination of how site context impacts on implementation is important to the evaluation. Below is a brief description of each site. More detailed site profiles are available in ARACY's interim report (accessible at: <http://www.aracy.org.au/cmsimages/file/ARACY%20CAARS%20II%20final%20interim%20report.PDF>).

Interrelate Lismore is a non-government community service organisation which provides a broad range of family support services and programs, such as personal and family counselling and dispute resolution services, children's contact services, and programs such as positive parenting and anger management. The organisation is primarily located and well-established within Lismore, however, a network of connected centres and outreach sites provide services across metropolitan, regional and rural NSW. Given the diversity of services and programs offered, site practitioners can often refer clients internally. Practitioners who have trialled CAARS within this site include social workers, counsellors, and family lawyers.

The Gippsland Lakes Community Health Centre (GLCH) provides health and community services (aged care, district nursing, allied health, family, youth and children's services, and koori health services) across a large and relatively remote area of Victoria. Multiple service sites are located throughout the region and outreach services are also provided. Practitioners working at the site include maternal and child health nurses, social workers, counsellors, and community service workers.

Northern Connections is a small state government agency which functions to connect government and non-government service provider organisations to improve outcomes for communities in the northern suburbs of Adelaide. It does this by working on strategic regional priorities and initiatives directed towards improvement and systems change. Northern Connections is not a service provider organisation but includes multiple partner organisations that have trialled CAARS. Partner organisations include the Northern Adelaide Regional Health Network, the Women's and Children's Health Network, the Department of Education and Children's Services, the Adelaide Northern

Division of General Practice, and Goodstart Child Care Centres. Practitioners and clinicians who have trialled CAARS at this site include nurses, midwives, student counsellors, teachers, and childcare directors.

The Rockingham Kwinana Division of General Practice is located in outer Perth and provides medical, health and community services to the local community. The local community is diverse and growing and includes many newly migrated families and a large Aboriginal population. Service practitioners who have trialled CAARS at this site include nurses, Aboriginal health workers and migrant workers.

All sites include a high proportion of disadvantaged families; the provision of services to vulnerable clients was a criterion for site selection. This was to ensure a level of need in trial sites. However the high level of disadvantage has also been a barrier to CAARS implementation in some sites. This is because some practitioners have been reluctant to use an early intervention instrument with families whose needs have already been assessed and who are already receiving secondary support services. As reported from the Rockingham Kwinana site:

The barriers that we are facing when trying to implement CAARS are that for those children/families already in the 'system'... they have for the most part already been assessed, their needs identified and placed within suitable programs. For the most part the assessment has been carried out in schools of which these organisations have close links by nurses, counsellors, liaison officers. Feedback therefore suggests that existing assessment tools are in place and working... This has led to the uptake of the CAARS tool being significantly slower than we anticipated (Rockingham Kwinana Progress Report, November 2011).

As a result of trialling CAARS in sites with a high proportion of disadvantaged families, many of the practitioners that have used the materials have been attached to secondary support rather than universal services. Throughout the evaluation, secondary support practitioners have shown their comfort and competence in engaging vulnerable families in conversations to identify support needs. However, the aim of CAARS is to extend child welfare responsibilities to universal practitioners, who have sometimes shown a reluctance to take on an expanded role. It seems apparent then, that future CAARS implementation should be better targeted to universal services.

As evidenced above, the sites chosen represent a diversity of organisational structures and models where CAARS has been trialled by a range of different practitioner groups. This variety and contrast has enabled the identification of inhibiting and facilitating factors to successful CAARS implementation within a relatively short time period. Data findings are presented in the remainder of this report.

3.2 Practitioners within sites

Second round interviews were conducted with 35 practitioners across the four trial sites as shown in Table 2 below.

Table 2: Practitioners interviewed for round 2 data collection

	Adelaide	Gippsland	Lismore	RKDGP	Total
Child and family support workers, e.g. assessment and response, family mediation, dispute resolution, parenting/maternal/family programs	1	3	6	1	11
Social workers- drug and alcohol	2				2
Case workers			1		1
Legal practitioners			4		4
Peri-natal Mental health nurse	1				1
Youth worker	1			1	2
Coordinator of Aboriginal programs	1				1
School support staff	2			1	3
Maternal and child health nurse		2			2
Counsellor/ therapist			1	3	4
Nurse				3	3
Manager Mental Health Programs				1	1
Total	8	5	12	10	35

Table 2 provides a snapshot of the practitioners trained in using CAARS, however, it does not highlight the extent of the variety of practitioners engaged to trial the tools. At each site facilitators endeavoured to recruit a diverse mix of practitioners and organisations to trial the CAARS materials. A brief overview of these practitioner groups is provided below and a comprehensive list of practitioners and organisations that have been trained to use CAARS can be found in Appendix D.

In Adelaide, a total of 122 practitioners were trained in how to use the CAARS materials. These practitioners included social workers specialising in maternal and child health, early childhood education and care, Aboriginal and mainstream mental health, child and family support, family law, and various community and hospital-based positions such as nursing and midwifery. A dozen clinical managers were also trained to use the tools so they could provide ongoing support and encouragement to their staff. The Adelaide site facilitator also engaged several of the local schools to train a number of key support and executive staff to use the tools. These practitioners included school counsellors, assistant principals, and student and family support workers.

In Gippsland, the focus of the site facilitator was on promoting the tool in-house and of the 30 practitioners trained to use CAARS, half were from the service provider organisation (GLCH). External practitioners trained to use CAARS included midwives, school teachers, and early childhood education and care workers. The GLCH staff trained to use the tool included maternal and childhood nurses, intake, assessment and response workers, and family and parenting program workers.

In Lismore, a total of 58 practitioners have been recorded as undertaking training to use CAARS. The site facilitator firstly focused on training internal Interrelate staff to use the tools. These practitioners included family law mediators, family dispute resolution practitioners, counsellors, children's contact workers, and family and parenting program workers. Training with these practitioners became an ongoing process of practice and reflection as CAARS was a permanent agenda item at staff meetings for the duration of the pilot period. Once Interrelate staff had been adequately skilled to use the tools, the facilitator moved to focus on practitioners within local and partner organisations to promote the tool. External practitioners trained to use CAARS included school teachers, public and private family law solicitors, Brighter Futures Early Intervention caseworkers, a high intervention caseworker, and a paediatrician.

The Rockingham-Kwinana site facilitator also engaged a range of different service and practitioner groups to undertake CAARS training. The exact number of practitioners trained was not recorded, however types of practitioners included counsellors and mental health workers, youth workers, young mother program workers, Aboriginal health workers, early education and care workers, general practitioners, maternal, child and family support workers, and a variety of nurses in roles such as Aboriginal health, midwifery, and child and adolescent health. The school sector was also engaged at this site and a number of school staff were trained including student support workers, teachers, assistant principals and principals.

3.3 The role of site facilitators

The pilot model included one or two facilitators (also known as CAARS Champions) at each site to train, encourage and support practitioners to use the materials. Data indicates that the role of facilitators was crucial in ensuring that target usage numbers remained a sought-after goal, and that obstacles to implementation were grappled with, and in some cases overcome.

During round one interviews, site facilitators spoke of volunteering to participate in the trial because they felt that CAARS would enhance their existing practices with children and families, and/or improve collaboration within the local service system:

I have faith in [CAARS]... And I think if we could get a lot of people using it, I think it would be fantastic, I really do.

We obviously connect with a lot of services here within our own organisation and also outside. So there's often issues with communication and people understanding where you're coming from, so I thought it was a really good opportunity to be able to be part of that, and just to assess a tool and see if it was actually useful for our service and other services.

Most facilitators viewed their role as being a point of contact for ARACY, providing training on use of the instruments in their sites, and providing feedback for ARACY and the evaluation. Towards the end of the pilot it was

clear that facilitators had not anticipated the level of persistence required to get practitioners to use the tools. In particular, facilitators had expected that the promotion of CAARS within external organisations would be handled by managers within those organisations. In practice, however, site facilitators needed to promote the use of CAARS to all levels of management and practitioners of organisations as well as provide ongoing training and support for use. Two facilitators commented that successful implementation requires a clear commitment from partner organisations to promote the use of CAARS within their own organisations.

The tasks undertaken by site facilitators during the trial varied according to the organisational structure and site features. Most facilitators engaged in:

- Training practitioners to use the CAARS materials;
- Modifying the training material provided by ARACY and adapting this for specific practitioner groups at sites;
- Promoting the use of CAARS to managers and practitioners within provider and partner organisations;
- Providing ongoing mentoring and support to practitioners using CAARS;
- Providing regular information and feedback to ARACY and evaluators; and
- Engaging in trial community discussions and interactions.

The role of the facilitator was less onerous in sites comprising service provider organisations as opposed to agencies set up to coordinate services. In the Adelaide site the facilitator spent much time early on in the trial making connections to service provider organisations and promoting CAARS.

Facilitators appear to have underestimated the time and effort required to get practitioners to use CAARS. For some facilitators this was because they came up against unexpected barriers to usage at their site. These included CAARS duplicating existing and adequate assessment practices. However, as well as attempting to overcome specific barriers at individual sites, facilitators also had to deal with a degree of resistance and cynicism by practitioners related to trialling what was sometimes viewed as another assessment instrument. This resistance was evidenced in some practitioner interviews.

Finally, ARACY also felt that the facilitators were crucial to trial success:

It's important to have somebody that practitioners can go to and say 'hey this isn't working, what could I try?' – I think that there does need to be somebody in the organisation who's seen as an expert and seen as a point of contact and feedback.

While the site facilitator model required more time and effort than anticipated, it was a foundational feature of trial success. One facilitator felt that their role in the trial would have been made easier if FaHCSIA had more forcefully promoted CAARS through mandating its use by funded provider organisations. This suggestion is presented here for consideration for the next stage of implementation. Any broader rollout of CAARS will require dedicated and intensive work at sites if sustained use by a broad range of practitioners is the goal.

3.4 The role of ARACY

ARACY played a key role in the trial and evaluation of CAARS. As noted by nearly all site facilitators, ARACY project staff worked hard to ensure that the trial implementation reached target numbers and achieved established goals. Garnering support from site facilitators and the evaluators to extend the trial period was essential to achieving this outcome and ARACY project staff were able to do this because of the close working relationship they established with all during the course of the evaluation.

Site facilitators commented on the importance of ARACY in providing the structures to connect trial sites and enable the sharing of practice stories and questions. ARACY facilitated exchange across sites through regular group teleconferences and group email communications directing site champions to BaseCamp – a web-based community where members could read documents and post comments. There was little evidence of the effectiveness of this online community in data collected for the interim evaluation report, however during a recent teleconference with all site facilitators it was evident that many had read each others' progress reports with some commenting on the positive implementation stories from other sites.

ARACY staff also undertook site visits and regularly communicated with facilitators from individual sites through telephone calls and emails. ARACY project staff were described as being 'very responsive' and 'quick to come back to us on issues'.

Site facilitators appreciated the freedom that ARACY gave them to engage in trial and error activities during the course of the project:

[ARACY] gave us, if you like, a lot of licence to be able to try things and they were very encouraging with that, which was really good. Because often when you do see projects, you're very tightly bound to rules, if you like, and what you can and can't do, but they've actually been allowing us to be quite creative with it, which has been really nice.

We did the training with staff. Staff were very enthusiastic but then they went off and they didn't use it. We've had to follow up on that training to really get people using it and I think without ARACY behind us as facilitators for the trial supporting us, that wouldn't have really happened. So I'd say at the second stage of trying to implement it on a broader scale, you really need an organisation centrally trying to keep

the project on track and keep the goals clear and really assist in each area to implement something like this.

As well as interviewing site champions, we also interviewed two key project staff from ARACY to further explore their role. ARACY staff spoke of the difficulty of trying to ensure that the sites reached target numbers (250 per site), and felt that this focus on crude output measures distracted attention away from key learnings arising from the evaluation.

ARACY project staff indicated that they had not anticipated the extent of their role in coaching, supporting and motivating site champions:

I think we originally thought that ARACY's role was going to be front end and back end – that we would train and we would collect data – and what has been different to what I think was planned was that we have ended up doing a lot more coaching with the champions... a lot more facilitating.

ARACY staff felt that they played a crucial role in contacting site facilitators, keeping them motivated and providing intensive support – indeed, they argued that an intensive coaching model is required to ensure successful CAARS take-up. Towards the end of the trial period they had begun to focus their attention on CAARS usage beyond the trial. While their role in this project phase is yet to be determined, it is clear from project data that site facilitators require a central agency or organisation to provide training and implementation support. ARACY have been successful in this role and, rather than showing signs of project fatigue, have been keen to identify opportunities for future CAARS use and a targeted broader rollout.

4 An Assessment of CAARS

This section draws on multiple data sources to present an assessment of CAARS. The section is divided into three sub-sections which present findings on the appropriateness of CAARS; the impact of CAARS; and the engagement of different stakeholder groups with CAARS.

4.1 The appropriateness of CAARS

Practitioners have provided valuable feedback about the appropriateness of using CAARS with particular client groups, and in particular contexts. In relation to Aboriginal clients practitioners reported that it is problematic that the tools do not have a cultural focus or domain. This was considered important as there was no opportunity to explore cultural identity, connection to land and culture, trauma associated with stolen generations and other issues central to wellbeing for Aboriginal people.

A number of Aboriginal practitioners commented that they recognised that the tools had not been developed with Aboriginal clients in mind. One practitioner commented that the tools may be unsafe in the hands of non-Aboriginal human service workers because they could result in unnecessary risk of harm notifications. This practitioner believed that the structure and language of the questions are written in a way to indentify mandatory reporting issues, despite the tool not being developed with statutory child protection in mind:

In the order those questions were in and the way they were written, we probably would have come across mandatory report [issues] that we were forced to put in by law and by conscience.

The practitioner went on to say that if there was a risk of harm issue that required reporting, it should be uncovered in a more culturally appropriate way. This practitioner suggested that an Aboriginal panel, or at least an Aboriginal advisor is needed to ensure the wording is culturally competent and safe. This suggestion was echoed by several other Aboriginal practitioners, one of whom pointed out that a reference group would also need to consider the diversity of Aboriginal people and cultures across Australia.

Some Aboriginal health workers felt that the intensive questioning in all tools could be considered intrusive by Aboriginal people and cause them to shut down and not disclose anything out of fear of how the information would be used and who it may be passed onto. This issue was also raised by practitioners working with non-Aboriginal families, however because of the history and trauma associated with Aboriginal child removal, Aboriginal families were described as particularly sensitive to intrusive questioning. While this is undoubtedly an issue, other evaluations have highlighted anxiety amongst non-Aboriginal human service workers in exploring sensitive issues with Aboriginal clients.

Some Aboriginal practitioners also felt that using the wheel with Aboriginal families may not be appropriate as it could be seen as a mechanism for documenting evidence against the family or parent. Further, questions around

stable housing and space in the home were viewed as irrelevant due to the transient lifestyle of many Aboriginal people. The questions around reading to children were also described as inappropriate because Aboriginal culture values oral storytelling. This practitioner suggested that the question ask instead about parent interaction with the child rather than engagement in a specific activity.

Another practitioner commented that Aboriginal children may feel uncomfortable answering some questions honestly for fear that their parents may be reported:

Aboriginal kids anyway are not going to talk about if their parents argue in front of them.

For inexperienced or untrained workers the CAARS tools provide a clear direction about the types of topics to address with clients, however these workers can face challenges when information is disclosed to them and they do not know how to proceed. For example, one practitioner working with school children commented that she has encountered several instances where a child has made disclosures of abuse while using CAARS. Besides making a notification to child protection services, this worker was unsure of what other actions to take following making notifications.

A number of practitioners commented that while some of the materials could be better tailored to suit CALD families and those with low literacy levels, others felt that this task could be accomplished by competent practitioners:

Some of the wordings I thought maybe that needs to be simplified... but I reckon whoever was giving it could probably tailor that to the level of their client.

Some family law practitioners commented that they would not use the tools with parents who had limited contact with their children because they may not be able to answer many of the questions, and it could also be traumatic for a parent to be confronted with the fact that they know little about what is going on in their children's lives. One practitioner felt however, that the wheel can be effective when used hypothetically with parents to get them thinking about how they are going to practically meet the needs of their child(ren).

In the Rockingham Kwinana site practitioners identified that the CAARS tools are particularly suited for use in primary schools to accompany student health checks. Parents were provided with a consent form to allow the health check and CAARS questionnaire to be conducted. Prior to completing the health check, each child completed a questionnaire with the assistance of the program support coordinator. The program support coordinator, nurse and GP then reviewed completed questionnaires and, where necessary, had a discussion with the child about any of the issues raised. Practitioners have commented that using the CAARS tools with the health checks has made the process much more comprehensive as it provides a holistic view of the child's health and wellbeing. It was not common practice to ask about the child's emotional health or areas other than their physical health, and the CAARS

questionnaire has really helped to ensure a holistic assessment. In one instance where a child disclosed being abused when filling out the CAARS questionnaire, one of the practitioners commented, 'if I'd have just been there checking her height and her weight, she might not have opened up, but the fact that we gave her a booklet and asked her to talk to us, it might have been that'.

CAARS and other assessment tools

Data indicates that CAARS implementation has been less successful in settings where the use of other assessment tools are mandated through policy, supported through government subsidised payment schemes, or are a well established feature of practice. In these settings CAARS is generally seen as an instrument that unnecessarily duplicates, rather than enhances, established practice.

Healthcare practitioners at the Gippsland site are required to use forms and questions that comprise the suite of Service Coordination Tool Templates (SCTT) to record client information, assess client service needs, coordinate care or case-plans and refer clients to other services. Use of the SCTT's is a state wide, government initiative, developed to support service coordination practice throughout Victoria. The SCTT's are supported by user guidelines, electronic resources, data standards and privacy resources. Within this context, CAARS was largely viewed as an unnecessary, additional tool:

I think that we didn't use [CAARS] enough because we already had our own way of doing things... We would go to the first appointment and we'd forget to even take [CAARS] because we were just so into doing our own routine – because we've got like a whole seven page thing that we do with women, a seven page assessment... We probably should have used [CAARS] much more. We just didn't get around to it because we already had something.

We realised that it wasn't going to be possible to incorporate CAARS into what is already a very dense... very detailed process that nurses are obliged to do.

In an attempt to get around this, facilitators at the Gippsland site approached other healthcare practitioners to use the tool, but again CAARS was viewed as not adding value to current practice.

Some interviewees from the Rockingham Kwinana site also reported that CAARS did not fit well with existing practice. This was not only because many healthcare practitioners used alternative assessment tools in clinical practice (such as HEADSS³ and PEDS⁴), but also because CAARS is not supported

³ Home, Education/Employment, Activities, Drugs, Sexuality, Suicide/Depression (HEADSS) is a screening tool for conducting a comprehensive psychosocial history and health risk assessment with young people.

by the Medicare Benefits Schedule which subsidises the use of various health assessments. Because general practitioners (GPs) from this site could not claim for their time in using CAARS during patient consultations, it was not trialled by this practitioner group. Strict time limits associated with patient consultations, and the fact that CAARS was not a clinically developed or validated instrument, added further disincentive for medical practitioners to trial the various instruments.

The structural barriers of policy mandated and government subsidised tool usage could not be overcome during the trial period however the existence and use of other assessment tools within sites was not always a barrier to successful CAARS implementation. Indeed, many practitioners spoke of CAARS complementing current assessment and/or case management practice. In particular, interviewees commented on its usefulness in refocusing on families' strengths and the needs of the child(ren). Other practitioners commented on how the visual and holistic nature of the wheel enabled questioning around areas not directly related to the practitioner's field of expertise:

I think initially we saw it as something that maybe... I suppose distracted from a model that people had developed themselves. When we thought it through I think all of us felt it really was an extension of what we're doing but with a couple of additional tools.

What I've found is that [CAARS] is a great tool to help parents get focused. Often parents will present here and they just want to dump on the other parent, how bad they are, and they don't take any responsibility.

[CAARS] complements the [other] tools. For some of my clients that I used [the wheel] with they were good because they're a picture and pictures are actually quite good because they're not as threatening as a form. People think forms and they think documents, they think government, they think police.

In another site where health checks were being undertaken with local clients, practitioners used some CAARS questions to make their current assessment more comprehensive:

We haven't used the whole questionnaire because there's parts of it that aren't really appropriate and it's quite long-winded. So we've just taken out questions that we feel will make our health check a bit more comprehensive.

This finding is challenging as the data indicates that CAARS works better in sites where existing services are already being offered and there's an existing organisational structure to support delivery. This latter feature often includes

⁴ Parents' Evaluation of Development Status (PEDS) is a tool for providing developmental and behavioural screening and ongoing surveillance in children from birth to eight years of age.

the use of established assessment instruments. The data presented here indicate that certain factors such as government mandated tool usage and CAARS' omission from the Medicare Benefits Schedule may preclude CAARS usage in some contexts. In sites or settings where such structures are not in place, the aim is to train and support practitioners to see CAARS as offering additional value to current practices.

4.2 The impact of CAARS

This section presents the evidence about the impact of CAARS on practitioners, families and the service system.

Practitioners views of the impact on families

The formative evaluation of the CAARS trial did not focus on an outcomes assessment as the time span of the project was too short, and there was no systematic comparison between families who did and did not engage with CAARS. However during interviews, practitioners were asked to discuss their beliefs about the usefulness of CAARS in helping children and families, and their use of the materials with families. The data collected does give an indication of the impact of CAARS on families as perceived by practitioners and this is presented below.

The site progress reports contain many examples of good outcomes for families and/or children following use of CAARS materials – and this is consistent with data collected during the interviews. Practitioners gave examples of positive outcomes for families and parents including gaining a clearer understanding of how to better meet the needs of their child(ren) by being able to reflect on family situations and discuss issues with each other or a practitioner; gaining more positive feelings of wellbeing through the identification of family strengths and the act of talking to a caring practitioner; connecting or re-engaging with a wide range of community supports and services; and feeling empowered enough to make positive changes in their lives. Positive outcomes for children described in progress reports and interviews included child re-engagement with education services (schools and kindergartens); referral to and provision of various support services and resources; and improved family functioning and wellbeing. In a couple of instances children were identified as being at risk of harm through the identification of serious issues. In these cases, practitioners reported that a child protection notification to the relevant statutory authority was made.

While the positive examples described by practitioners are encouraging, it needs to be remembered that CAARS materials have often been used throughout the trial as part of an established and lengthy assessment process. In this context, it is uncertain whether the positive intervention and/or response families' received was a result of CAARS or of the established assessment process – indeed many practitioners reported CAARS questions duplicating those already asked.

Still, the data includes examples of families having positive outcomes as a direct result of a CAARS conversation. This was especially evident during the interview of a childcare director:

All the parents I used it with ended up changing what they were doing and modifying their home environments or where they were living or what they were doing as a consequence of that conversation.

This practitioner further described how these positive outcomes were a result of childcare staff feeling more able to take a proactive approach to child protection and wellbeing:

Evaluator: OK, so would you say that CAARS has changed the way you think about the families that come here?

Interviewee: It has but it's also made us probably access more readily some help for the families. Whereas before it was a sort of watch, wait, see and report – now it has sort of given us a tool that we can [use to] get in before that and have the more meaningful conversations with the parents, and I thought the effect would be that they would go to different agencies, but the effect has been that they've been able to sort of reassess their life... The consequence for the children has been the most important thing – that they aren't in such a devastatingly vulnerable situation.

Impact on practitioners

Despite the positive impacts outlined in the section above, there was also reluctance from some practitioners to use CAARS. The research team interviewed 5 practitioners who refused to use CAARS. The concerns of most of these practitioners centred around the inappropriateness of CAARS for their professional practice. There was anxiety among some practitioners about the responsibility they took on when having a CAARS conversation with a family or child. Some practitioners expressed concern that they were not competent in dealing with vulnerable children and families and others were concerned that they identify a problem without having the skills or resources to ensure that families received an appropriate response. Evidence from interviews identified gaps in both skills and confidence among some practitioners.

Impact on collaboration

One of the aims of CAARS is to facilitate collaborative working amongst practitioners to ensure that the holistic needs of families are met. Interview data suggests that CAARS has made little, if any, impact on collaborative working in 3 of the 4 trial sites. Practitioners from Rockingham Kwinana, Adelaide and Gippsland consistently reported there they had not noticed any change in collaborative work since the use of CAARS. Many practitioners from these sites reported that they had established partnerships with other agencies and provider organisations but that CAARS had not changed the way these working relationships functioned.

Evaluator: So have you found that CAARS has changed the way agencies work together in the local area?

Interviewee: No, I haven't found that myself.

Evaluator: How closely does your organisation work with other services in the area and has CAARS changed the way agencies work together?

Interviewee: We work very, very closely and we have for many, many years. It's one of our primary functions to maintain strong key stakeholder links through meetings, through referral pathways, through personnel and clinicians getting together and having that really strong local knowledge. So I think CAARS hasn't changed that in any way.

Evaluator: How often would you say that you collaborate with other services?

Interviewee: Daily.

Evaluator: Has CAARS changed the way that agencies work together in the community?

Interviewee: No.

One participant from the sites where CAARS had made no apparent impact on collaborative working explained that her organisation had used CAARS to assess families and did not share copies of assessments using the wheel with provider organisations to which they referred families. In this site, as perhaps in others, CAARS had predominantly been used as an internal assessment tool rather than an instrument to facilitate information sharing across practitioner groups.

Another participant from Rockingham Kwinana stated that she felt that CAARS had made little change to the way that practitioners worked together because:

I don't think we took [CAARS] on board in a big way. It was kind of introduced to us very rushed, sort of ad hoc and we were told we have to try and use it in some ways because we had committed to it.

Evaluator: Have you found that CAARS has changed the way organisations work together in the community?

Interviewee: No I don't think so because certainly we haven't done any referring into the community using it.

Finally, a few participants from the sites where CAARS had seemingly made no impact on collaborative work commented that they didn't know if other organisations that they referred to knew that they used CAARS, and similarly they did not know if other organisations were using CAARS. These findings suggest, not surprisingly, that a restricted use of CAARS (as an internal assessment tool) results in the instrument having little impact on collaborative working across organisations and agencies. Indeed one of the key principles underlying the CAARS approach is that organisations and professions who share a common language will be enabled to work closely together. In contexts where agencies already do share a common language, or where CAARS is not used by a range of organisations, CAARS is unlikely to make a difference to the level of inter-agency collaboration.

In contrast to the views of the majority of interviewees, 5 practitioners felt that CAARS had impacted on collaborative working with other agencies. 4 of these practitioners were from the Lismore site. These practitioners generally felt that CAARS had broadened their views about referral options:

Well in some ways – in having the broader conversations with people, particularly using the outer rim of the wheel, it helps to identify more precisely I suppose the areas of need for a particular family. Once you identify the areas of need for a particular family it opens up your opportunities to look more towards broader referrals.

We currently – very readily we use referral services to policy, specialists in domestic violence order, we work very closely with people like the community legal centre, with Interrelate, with domestic violence support groups, with DoCS, so there are probably five services that prior to CAARS we were working with. But I guess CAARS provided some additional options.

It's probably given me a better awareness of referral and that's kind of something that I've had to learn all the way through my practice as a mediator. Coming from being a lawyer it's been a bit of a learning curve for me, that networking and that sort of spreading out and engaging other services and something which is an ongoing learning curve for me.

This outcome suggests that practitioners in the Lismore site are using CAARS not just as an instrument for assessment, but as a way to facilitate having a deeper conversation with families so that the best response is provided. The quotes above suggest that some practitioners have broadened their view of referral beyond local secondary support services to include less frequently considered options.

The need to provide further training on referral pathways and various forms of practitioner responses following the conduct of a CAARS conversation with families was identified early in the evaluation, and ARACY responded with the inclusion of further information in training presentations for champions and practitioners (dated March 2012 and accessible via BaseCamp). The findings suggest that CAARS has helped some practitioners at the Lismore site (where CAARS usage was successfully and in some cases intensively supported by site champions), rethink their immediate responses to children and families that may need some additional support.

CAARS in different sectors

CAARS had varying impact on professionals from different sectors as each have different priorities, traditions, cultures and professional languages. This section reports on the implementation of CAARS across sectors for which we received relevant data. Due to the overall small number of sectoral representatives that participated in interviews, caution regarding overstating conclusions needs to be taken. The discussion of findings below is presented as preliminary and tentative.

Mental Health

A range of mental health practitioners were interviewed during the second round of fieldwork. Data indicates that mental health clinicians – many of whom were trained at the Northern Connections site - can have different and even contrasting views about CAARS. Some mental health workers spoke of seeing clients who have already been comprehensively assessed. Within many mental health services, clients must obtain a Mental Health Treatment Plan and Assessment from a General Practitioner prior to receiving a service. This assessment ensures that some clinical services are subsidised by Medicare. This comprehensive assessment is received by the mental health worker who is then required to complete additional assessments which are common across primary and secondary mental health services. These common assessments are validated tools used to diagnose clinical conditions. In this context it was seen by practitioners as a waste of time to engage the client in a further assessment using CAARS.

In contrast, a Headspace⁵ youth worker gave a different view. They found the CAARS wheel to be a valuable addition to intake processes – and equally useful in assessments with the parent or the young person. This circumstance perhaps reflects the fact that young people can self refer to Headspace which operates on less structured referral mechanisms. In secondary and tertiary mental health service contexts however, CAARS was generally viewed as not adding anything worthwhile to the significant assessment process that clients currently have to undergo – and that is used essentially to inform clinical diagnoses.

Thus the weight of the evidence suggests that CAARS can be used in mental health service contexts, but is best located in primary prevention contexts such as Headspace and other community outreach facilities. It is less effective in secondary and tertiary sites which cater for clients with complex needs and who have already been comprehensively assessed and diagnosed.

Family Law Services

The research team interviewed 3 lawyers who worked predominantly in providing family law services. Each of these lawyers had been introduced to the CAARS materials by site facilitators but each had independently chosen not to use CAARS. While these lawyers stated that they could not speak on behalf of the practitioner group, they felt that CAARS did not fit easily into the work practices and priorities of lawyers.

My original and current difficulty with it is I don't think it works in a way that... [assists] lawyers to identify the legal issues and to look at what is in the client's best interests in terms of getting a result... It didn't really help me to identify what were the solutions to legal problems... It was

⁵ Headspace is the national youth mental health foundation that provides health advice, support and information for people aged 12-25.

perhaps instructive and informative about relationships between parent and child... but not so much productive in terms of relationships between parent and the other parent in the family law context.

We normally don't tell our clients how to parent. What we're normally doing is collecting the facts and putting those facts together in the form of an affidavit, then advising our client under the circumstances what we think is the most likely outcome.

We interviewed a very small number of lawyers, however all viewed CAARS as an assessment tool – and felt that it was not part of their role as a lawyer to conduct a 'needs' assessment with client children or families. This was partly because of a belief that this type of work was best undertaken by family support service practitioners or others qualified in providing therapeutic support, and also because often client families had children that were being assessed through appropriate court appointed practitioners. To this end, two lawyers suggested that CAARS would be more suitable for use by Independent Children's Lawyers or Children's Court Clinicians.

Another barrier to the use of CAARS by family lawyers relates to the stage at which they come into contact with families. As one lawyer stated:

Normally when [families] are in our office the worst case scenarios have already happened.

The lawyers interviewed regarded CAARS as a tool to assist in the early identification of needs or problems, however, they spoke of intervening in the lives of clients only when family functioning had broken down so greatly that court intervention was required.

Some respondents suggested that CAARS was particularly inappropriate in cases where the separated parents were more concerned with revenge and dividing settlement, than working on ensuring the needs of their children were met. Practitioners suggested caution in using the tools in a way that could be used to build evidence against another parent, because 'all you're doing is giving them resources to fuel their conflict because they'll use that measurement or those questions in that book on the other parent and say this is what they're doing wrong'. This practitioner suggested that CAARS may be more appropriate in later sessions with the client, once the legal issues have been negotiated and managed.

The small amount of data collected from family lawyers therefore suggests that CAARS does not fit well with the work patterns and purposes of this practitioner group. The family lawyers interviewed were experienced and competent in engaging families in conversations around sensitive issues (such as drug use, criminal behaviour and mental health history) however their purpose in undertaking these conversations was to achieve the best legal outcome for their client. One lawyer admitted that functioning in a way that prioritised the provision of family support may help to shift the profession 'away from the adversarial model of litigation to something that is more

conducive to resolution of family breakdowns' (Lismore Progress Report, May 2012). However, this was considered to be a 'pie in the sky' aspiration.

Early Childhood Services

During the time that fieldwork was being conducted for the second round of interviews, a large non-profit early childhood service provider organisation approached the facilitator at Northern Connections to discuss using CAARS within their organisation. This organisation viewed CAARS as a set of tools which could improve the ability of their largely under-qualified staff to build better relationships with parents, assess families' needs and strengths, and ensure the wellbeing of children.

As part of the fieldwork at the Adelaide site, we interviewed one practitioner from this sector – a centre director. However, during the trial period a range of early childhood practitioners were trained in CAARS. During the interview the director reported on the use of CAARS within her multi-centre organisation. The director described how the instrument had made all staff more aware of their responsibility to provide support for client children and families. She also reported that the CAARS conversations that she had had with families resulted in referrals to other services including Centrelink, the Police, occupational therapists and speech therapists. This director had also googled community information and had printed off and handed parenting information with advice and telephone helplines to families. The director stated that she saw a positive change in the few families that she used CAARS with. As she stated:

I had one of the parents, the one that we had that we referred to the police as well for the AVO. She did access them and accessed Centrelink and went into a sort of a safe house type thing for a while and left her home... At the same time we organised her a transfer to another [childcare centre] so she was away from her partner and that he didn't know where she had chosen to live. So we sort of did that coupled with CAARS as well and so they were all actioned.

The data collected is obviously insufficient to show the impact of CAARS on early childhood service providers. The director interviewed believed that the valued relationship with families that many early childhood education and care staff develop made CAARS an appropriate and easy resource to use within the sector. However, while initial indications are promising, it needs to be remembered that sectoral services are provided by a diverse range of organisations including many small for-profit providers that may be reluctant to fund staff training not directly related to significant policy initiatives such as the Early Years Learning Framework.

Education

Throughout all sites, the school sector proved difficult to meaningfully engage in the trial. A range of school staff including principals, assistant principals, teachers, school counsellors, school nurses and student support officers were trained in the CAARS approach and materials, however, use of CAARS within school settings remained infrequent and relatively unconnected to daily routines and practices. This may be a direct result of the time it took to engage the school sector – with the Adelaide facilitator spending much trial time attempting to garner support from educational authorities, before abandoning that strategy in favour of approaching principals at individual local schools.

During interviews practitioners described a number of uses of CAARS within schools. One practitioner – a recently appointed community development officer within a school – reported that she found the tool helpful in defining and establishing her new role. This practitioner was a highly experienced social worker but her job description limited how much counselling she could undertake. During an interview this practitioner reported that the wheel helped her to engage with parents in a way that focused on their support needs including referrals to local agencies.

CAARS materials were also trialled by a nurse as part of her regular health check clinic conducted at a school. The nurse reported gaining consent from parents and carers for Year 6 students to complete the CAARS questionnaire. While the nurse spoke of the time difficulties involved in undertaking individual student assessments during outreach clinics, she did describe CAARS as enhancing her current practice:

Using CAARS alongside the health check has brought up some issues that we would – maybe not have approached... We did have one little girl that we brought in for a health check and as she started filling in the questionnaire to CAARS she did sort of open up a lot. I think it was very upsetting [for her] and she ended up not even finishing her CAARS questionnaire and it went a lot further... Whether it was the actual prompting of the questionnaire, us asking those questions, I don't know – because it was referred back to the health teacher at the school and it went further [to a statutory notification]. But as far as that goes then from our point of view with the health checks, that's where we leave it. We don't get involved in anything further than that.

Another use of CAARS within a school setting involved the completion of the 'About Your Wellbeing' questionnaires by Year 10 students in two health education classes, within a public secondary school. These classes were led by a site facilitator who was positive about the effectiveness of CAARS in identifying individual need in a group setting:

I've kind of picked up that there are probably some kids that are a bit at risk, maybe a couple who are quite highly at risk.

However, the facilitator felt that this form of usage required the practitioner to possess sophisticated skills in being able transpose questionnaire responses into identification of need. Further, the facilitator commented on the heavy workload required to review the information contained in multiple questionnaires.

The restricted use of CAARS by specialist staff within schools is problematic because it indicates that CAARS has yet to be trialled by teachers. Some data suggests that teachers approached for the trial were reluctant to take on what they considered to be a 'counselling' role with students and their families, as they felt that this was the domain of specialist school staff. It is clear that more work is required for teachers to embrace an expanded role in primary prevention and child wellbeing.

Health

Health-based service settings post particular challenges for CAARS usage. This is because client assessment requirements are often mandated and structured into service provision within these service settings. Further, assessment instruments within healthcare are generally clinically validated and used to inform diagnosis and response. Some healthcare practitioners expressed reluctance to use CAARS because it was not a validated instrument.

Further, CAARS requires healthcare practitioners to work in a way that is different to their ingrained orientation towards tertiary response:

CAARS is preventive and a very early intervention tool and there's incredible value but it seems like perhaps health and clinical practitioners haven't been brought to the stage where they're in a situation where they're thinking about – more about prevention and early intervention – they're thinking about now we've got the problem and we've got to sort of respond. So they're reactive and they're not proactive.

Health practitioners were the least engaged with CAARS, with some refusing to trial the instruments and other categorising them as more appropriate for intake assessments.

4.3 Engaging with CAARS

The CAARS conversation

The way CAARS was introduced to clients varied significantly between sites and practitioners. Some practitioners formally introduced the tool or the conversation as part of a research project and presented clients with a consent form, whereas other practitioners had a CAARS conversation without informing the client or showing them any of the materials. The way a practitioner engages with clients in the CAARS conversation process is dependent on a variety of factors, including their confidence using the tool, the time they have with the client, the appropriateness or suitability of the

materials with clients, their profession, and how they have been trained to use the CAARS tools.

Some practitioners at Rockingham-Kwinana chose to have a CAARS conversation without presenting the CAARS tools to clients. For example, one mental health practitioner commented that she preferred to not use the materials with clients during therapy sessions because she did not want the materials to distract from the therapeutic process.

Some practitioners used the CAARS materials as a resource for parents to reflect on their own parenting and come to their own conclusion about areas of need. This method was typically used when the practitioner had little concern that there were any child protection issues present within the family, but when the parent had identified that there were some areas they were struggling with:

So maybe I'd give to them and just say for them to go through and have a look through and just see if they see any issues there.

If the client had identified any need for services the practitioner had a list of local support agencies attached to the CAARS tools that they could use to provide referrals.

Training and support

The training practitioners received in using CAARS varied at each site. As indicated in the interim report, many facilitators felt that the original training materials provided by ARACY were too heavily focused on background information and had an insufficient emphasis on practical application. All site facilitators spoke of altering the training package so that it was more relevant to practitioners' profession and organisation. As stated by the Adelaide site facilitator:

We adapted the new ARACY training presentation to local needs, with each of our presentations tailored to the specific focus of the agency, local issues and the opportunities to develop partnerships (Progress Report Adelaide, April 2012).

Additionally, the site facilitators only had a limited time with practitioners so found that they needed to condense much of the information from the initial training package.

In Adelaide, training was conducted in both small and medium group settings (up to twelve practitioners), and on an individual basis. Training dates were planned well in advance to accommodate the limited availability of the various practitioners, with much training provided during staff meetings of individual organisations. Given the time constraints of practitioners, training was condensed to a maximum of two hours. The training consisted of an overview of CAARS and the purpose of the trial, followed by an explanation of the materials, with particular focus on the wheel. As a result, this tool was used most frequently by practitioners. The site facilitator prepared a variety of case scenarios to present to the different professional groups as a way to introduce

them to the CAARS materials in a practical way. Practitioners were also provided with information about referrals and how to navigate online resources for referral information.

The site facilitator provided ongoing support and advice in using the tools after the training and remained in regular contact with practitioners via phone and email. Many of the practitioners also attended refresher training sessions, with the facilitator reporting that it was more effective if additional training and support was provided within two to three weeks after the initial training.

Feedback from practitioners in Adelaide regarding the training was positive overall. All practitioners reported that the training they received for CAARS was well delivered and that after being trained they felt confident enough to use the tools, irrespective of whether they had intended to use the tools or thought they were appropriate for their client group. Responses were mixed to a question regarding the need for further training. Practitioners who reported that no further training was required were those who were either not using CAARS regularly because they felt that it did not add value to their work, or those who were using it regularly and felt satisfied with their use of the tool. Data suggests that for a number of practitioners using CAARS, it was not only the training that developed their competence in using the materials, but also their continued use of the tool with clients. Other practitioners commented that further training would be helpful to increase their confidence in using tools other than the wheel, and to see how the tool could be used in a different work role.

The approach to training in Gippsland varied according to the audience and available time of practitioners. In this site, the training ranged from an informal meeting with one or two people to provide a brief overview of the tools, to an intensive two-hour training session with a group of practitioners. From the small sample of site respondents (5), three had been trained in the group setting and two had been provided an overview of the tools in a one on one meeting. Comments differed with the type of training received. Those who received intensive training in the group setting were more confident in using CAARS, found the training very helpful, and did not feel the need for further training. In contrast, practitioners who received the more informal training said that they did not feel confident in using the tools and desired further training:

It probably would have been better to have a bit more training initially because we just sort of fumble our way through it and just use the bits that we see fit, so it would have been nice to have a formal session on the training and how it's used by the developers.

This practitioner also made the comment that 'we all use it differently I suppose'. This is problematic because one of the aims of CAARS is to develop a universal language between human service practitioners so that there is a degree of consistency and a shared knowledge and understanding regarding identifying and meeting the needs of vulnerable families and children. As such, when practitioners are introduced to the tool in an informal way and in isolation from other colleagues, they are missing out on developing a common understanding of the relevance of CAARS across all

practitioner groups and professions. Creating a forum where practitioners can engage in active discussion about CAARS provides them with the opportunity to reflect on their practice collectively and envision the role that CAARS can have in their work. This approach ensures a more collegial and universal implementation of CAARS across a range of practitioner groups.

In the Lismore site the training was highly structured and ongoing. Phase one of the CAARS training roll out consisted of training internal Interrelate staff, and phase two broadened the training to external service providers in the Lismore region. Like in Adelaide, the training focused heavily on use of the wheel over the other materials. The initial training of Interrelate staff consisted of an intense 1.5 hour session, with additional training delivered to several key staff who adopted a mentor role to champion CAARS and offer ongoing support and training to their colleagues. One on one training sessions were also delivered to Interrelate staff unable to attend group training. Depending on the time available, group sessions and one on one training with external practitioners ranged from 30 minutes to two hours. The longer training sessions consisted of the ARACY training materials and engaging in case scenarios to use the tools. The shorter training sessions focused more on presenting the tools and how to use them in practice.

Since the initial training and for the duration of the trial, Interrelate have commenced hour-long weekly team training and practice sessions to discuss using CAARS with clients. In addition, colleagues also kept CAARS on the daily agenda by sharing CAARS case studies via email and informal conversations as a way to learn and reflect on the implementation of the materials across the organisation. Through the ongoing discussion and training of CAARS in the workplace, practitioners felt more supported and encouraged to use the tools. The weekly meetings also provided the opportunity for practitioners to learn from the experiences of other practitioners using the tool. One participant who was reluctant to use CAARS at first commented that through hearing how CAARS was being used by his colleagues, he became more receptive to trialling the materials:

I guess it was a process of having the opportunity to hear other people's experiences that became one of the key drivers, I reckon...So you remember those conversations took place and that encouraged me to think, well, maybe I'll give it a try. So I guess that sort of process is what made it possible, I think, for people to come around to giving it a go.

This practitioner went on to comment how effective the strategy of having CAARS meetings regularly was key to its uptake:

If there'd just been training and then it was left or some check-in maybe a few months later to see if I'd used it or not, I probably wouldn't have.

Further comment was made about how the way CAARS was introduced at this site - with initial training and then ongoing collegial discussions and interaction around CAARS - led to a kind of cultural shift amongst practitioners

that facilitated exploratory practice and a change to methods that had been so ingrained in their way of working with clients.

For external practitioners, ongoing support was provided by key Interrelate staff who worked closely with them to build up their confidence and competence in using the tools. Some external practitioners, particularly solicitors, commented that they did not receive actual training in CAARS, but rather that the materials and information was just presented to them. As a result a number of these practitioners commented that they would have benefited from formal training to use CAARS in a way that was tailored to their profession as solicitors on the whole could not really comprehend the relevance of CAARS to their role. Additionally, some of the external practitioners, including those who had received formal training reported that they would have benefited from additional training in the form of role playing case scenarios to build the confidence of workers using the tools. This was expressed as especially needed when using CAARS with Aboriginal clients.

In Rockingham Kwinana the training was provided both formally and informally to practitioners in both group and individual sessions. During the training, depending on the audience and time available, participants were provided with an overview of the CAARS materials, and case scenarios to explain how to use the materials. The length of the training ranged from one to two hours. In some instances, the site facilitator provided the tools to practitioners for review prior to meeting, however this strategy appeared unsuccessful as it was clear that practitioners did not examine the materials prior to the training sessions.

Practitioners who were formally trained felt that the training was comprehensive and provided them with enough information to use the tools confidently. Responses from practitioners who only received informal information about CAARS were mixed regarding whether or not they would have preferred to have received formal training. Practitioners who worked closely with children and families, or who had a psychology background were more likely to be satisfied with a brief discussion and then figure out how to use the tools on their own, however other practitioners, particularly those with little experience or who worked with particularly vulnerable client groups, generally stated that they would have preferred formal training.

Much of the introduction that practitioners and the local community received in relation to CAARS was informal, consisting of the site facilitator contacting and visiting a variety of organisations and having a discussion around the tools, rather than presenting a structured training session. This provided the practitioner with an introduction to the project and information about how to request formal training if they were interested in furthering their involvement. The site facilitators also used the strategy of maximise exposure in the wider community in an attempt to gain interest in CAARS. For instance, CAARS was presented to a Community Consultative Forum at Rockingham Centrelink, a Communities for Children / Early Years Network meeting, and the Kwinana Rockingham Action Day for Today's Youth (KRAFTY) network meeting. These presentations lasted approximately 15 minutes and interested practitioners were able to approach the site facilitator afterwards to learn more

and organise formal training. However, this scattergun approach to recruiting practitioners to use the materials appears to have been unsuccessful, and perhaps was only employed because structural barriers inhibited use of the materials by practitioners originally targeted for the trial.

Finally, the Rockingham Kwinana site has a large Aboriginal population and many of the clients are Aboriginal. Several practitioners commented that the tools were inappropriate for Aboriginal families, however a number also commented that they would have benefited from further training in using the CAARS tools specifically with Aboriginal clients. In response, the practitioners at this site ceased using the tools with Aboriginal clients.

In summary then, the data indicates that the training has been modified at the sites to suit local structures and practitioner needs. This individual approach to training has been effective in many instances however it is time and labour intensive. Group training sessions with a range of practitioners appear to be the most effective as this provides a valued opportunity for practitioners working with children and families at the local level to meet each other and begin to establish collaborative relationships. However, it is also clear that training needs differ amongst universal and secondary service practitioners and the different levels of child and family welfare competence amongst practitioners needs to be taken into account. Evaluation findings suggest that training activities should focus on increasing the skill and competence of universal practitioners in engaging children and families in conversations that may be sensitive in nature and working with them and the local service system to address any identified need. Training most valued by practitioners was that which focused on practice examples, with facilitators also indicating that training needed to be followed up shortly after practitioners' initiation to CAARS.

5 Implications for further development

In this section we draw on data and evaluation findings to propose strategies for improving CAARS and ensuring its effective and sustained implementation.

Site and organisational issues

The relatively quick and successful adoption of CAARS by practitioners at the Lismore site suggests that the instrument is most easily implemented in sites and/or organisations that provide a range of services and have existing structures that support tool promotion and usage. These structures include regular staff meetings and other opportunities to facilitate the internal promotion of CAARS. More recent examples of successful implementation of CAARS by a diverse group of practitioners at the Adelaide site suggest that these structures are not essential, but that without them, further time is needed to establish practitioner engagement and usage.

There appear to be different routes to implementation in different contexts, and there is a trade off between on the one hand early uptake with a limited number of professions/agencies and broader uptake by a wider range of practitioners over a longer period. It should also be noted that the four implementation sites for this stage of CAARS provide limited information about the potential range of site contexts. Nevertheless there are some common lessons which can be learned and which appear to apply in most, if not all contexts.

Site differences in implementation suggest that successful take-up by site based practitioners depends upon visible, high-level support for the instrument by all management levels. This important feature was lacking in both the Gippsland and Rockingham Kwinana sites.

Another significant factor relating to CAARS usage within sites was the established use of other assessment instruments. In the Gippsland site, CAARS did not fit well with the state mandated requirement to use the Service Coordination Tool Templates (SCTT) within community healthcare settings to collect and record client information, identify needs, and undertake service planning. Data collected from the majority of practitioners interviewed from this site suggest that CAARS usage will not be maintained beyond the evaluation as it is seen as an instrument that duplicates much current practice. In one sense this is not really a problem for the CAARS approach. If there is already a common approach and language used by a range of practitioners in a site and practitioners are already opening out issues with families, then many of the basic principles behind CAARS are already being implemented. If this is the case then implementation of CAARS could even undermine practice. However there is a concern that practitioners may well be assessing clients, but not necessarily engaging them in discussions about their issues, or empowering them to take action, as is advocated in CAARS.

The evidence presented herein also indicates that whilst CAARS has been most successfully used by secondary service practitioners who have expertise

in working with vulnerable families, its take-up by universal practitioners to identify early need is still limited. This is an issue of concern, not only for CAARS but perhaps more significantly for the 'Child Protection is Everyone's Business' approach advocated in the National Framework for Protecting Australia's Children (Commonwealth of Australia, 2009). It indicates that many groups of universal practitioners are unwilling or unable to provide a context for families in which they feel comfortable discussing sensitive issues. The consequences of this are that many families are likely to feel that professionals are not available to help them. This may result in families delaying seeking support until there is a crisis and they are forced to do so – exactly the scenario that CAARS is designed to prevent.

This finding therefore indicates that it is important to better understand the structural and cultural barriers for universal practitioners engaging with families so that CAARS can be better targeted at this key group of practitioners.

CAARS materials

The vast array of materials had a tendency to confuse some professionals and so it is recommended that these be abbreviated and consolidated where possible. One site facilitator described the challenge of trying to promote the multiple tools that comprise CAARS:

I think that the tools, as they are, there's too many, they're too repetitive. So I think if someone could condense it down to a tool, then it will probably be a little bit more user friendly. I think it's been quite difficult going out and introducing this with all the resources. I mean initially we kind of took everything out and went through it all and you could just see you lost people straight away.

This comment was echoed by a number of other participants who found all of the different materials overwhelming.

Some practitioners have commented that the language and wording of CAARS requires modification to better accommodate families who may have low-literacy levels. However other practitioners have applauded the tool for being so inclusive because they found the wording to be simple and easy to follow.

There have been mixed responses as to whether or not a separate set of tools need to be developed for Aboriginal and CALD clients. What was clear however is that all practitioners commenting on this area stressed the importance of seeking relevant advice from appropriate cultural experts to develop the tools to be more culturally competent. Practitioners also suggested a number of specific language changes for the CAARS instruments. In particular, some practitioners felt that the words 'parent child attachment' were inappropriate for use with Aboriginal families, as were questions about reading to your child. In many Aboriginal families children develop close parent-like ties to a number of extended family or kin other than their birth parents, and therefore asking about parent child attachment

specifically excludes and minimises this cultural norm. Additionally, some practitioners have suggested changing the question about how often the parent reads to their child to how often they interact with their child to acknowledge the variety of ways that parents can educate and nurture the development of their children. This question also carries the assumption that the parent is literate.

During interviews, one practitioner stated that by focusing on the one activity of reading, the engagement may not be strengths-based as any other positive learning activities are disregarded in preference to reading. Several practitioners similarly commented on what they perceived to be a deficits approach feel to the tools. One practitioner suggested that strengths-based questions should lead the questionnaire so parents are not initially scared off by intrusive and negative questions. In regards to the tools that do not have a script, such as the wheel, it can be much harder for practitioners who are not trained in this area, such as teachers, to frame questions in a strengths-based way. One site facilitator commented that this has been problematic and challenging for practitioners because there are no instructions on how to have a conversation using the wheel so many practitioners do not know how to draw out strengths or highlight them to families. This site facilitator suggested an instructional DVD demonstrating how to use the wheel in a strengths-based way to maximise the chance of identifying both strengths and needs of families.

Specific components of the tools

Second round interview respondents provided feedback regarding specific CAARS components. Much of this feedback, reported below, echoed interim report findings.

Questionnaires

Many respondent practitioners felt that the questionnaires consisted of too many questions and they reported that some clients, particularly children and Aboriginal people, did not want to answer so many questions that may seem irrelevant or unnecessarily intrusive. As suggested by one practitioner:

I guess [you should] make the questionnaires a lot shorter. I don't know, it's very thorough, but I think a lot of it may be like, the clients might look at it and go why the hell are you asking me this question?

Another practitioner who works with children commented that the questionnaire is too long to hold the interest of children. She reported that they get bored answering the questions and as a result try to rush to finish, don't read the questions properly and therefore make inaccurate responses - 'I think if it's for the kids it has to be like basic questions for them'. Another practitioner made the comment, however, that by cutting out some of the questions it risks eliminating a key question that may be relevant to some client's situation.

Currently the child questionnaire presents as a replica of the parent questionnaire and consequently is not very engaging for children. Some

practitioners commented that the child questionnaire could be made more engaging by being redesigned specifically for children – that is, with more picture or images, as well as changed fonts and colours. Another practitioner suggested a wallet-sized fold-out questionnaire as this format is always popular with children and young people.

Wheel

Overall practitioners commented favourably on the wheel. The presentation of segments and colours is reported to be very popular with both practitioners and clients. A few suggestions for improvement however stem from the inability to record information on it. Many practitioners commented that they would like more space to write notes, which may be achieved by making the paper size that the wheel is presented on bigger - 'I would prefer an A4 sheet with the wheel in the middle where I could make notes all around the edge'. Another suggestion to record on the wheel is to develop a shorthand system to keep track of the areas where there are particular strengths or needs expressed by the client. As one practitioner suggested:

I thought maybe it would have been good to, I guess, have a way to record more easily the positive parts and negative parts.... Just thinking like even a place to maybe put in like pluses and minuses or something like that.

Another practitioner who found that the wheel needed more room to write client's comments, observations and referrals suggested that there could be a chart, or kind of booklet attached to the wheel that is colour coded to record all the corresponding information. A similar suggestion was that there needs to be a space close to the wheel to record the list of client's strengths, needs and referrals so that the client has that information to take away with them.

A couple of practitioners mentioned that although the wheel is comprehensive, it does not include some other areas that are vital to the work of specific practitioners, such as child development for child health nurses, or sleeping habits and difficulties for mental health practitioners. Another practitioner made the suggestion that there should be three copies of the wheel, one for the practitioner and one for the client, as it is now, but also one for the organisation where the client is referred so they are all provided with consistent information.

In regards to referrals, one practitioner made the insightful comment that the wheel does not allow a space for prioritising which needs to address first for families – 'I'd like to see some way of prioritising these issues that you identify'.

Directory of organisations

A number of practitioners expressed that they feel as though they are unaware of organisations to appropriately refer families to in the local or neighbouring communities, and would benefit from a community service directory as a part of the CAARS materials. This may even increase the

uptake of practitioners using tools as some have expressed that they feel as though using CAARS to identify referral needs is not helpful to families if there is nowhere to refer them to.

CAARS support

The findings presented in section 4 make clear that for CAARS to be effective in facilitating cultural change then ongoing support for practitioners is required.

If CAARS is to achieve the key aim of ensuring that child protection is seen as 'everyone's responsibility' then ongoing training and support is needed for practitioners to whom this role is new.

We have found that for many practitioners, addressing child and family welfare concerns is a challenging task and not just a matter of better understanding or lack of appropriate tools. To work effectively in this role, practitioners need to understand children and families holistically, including an understanding of children's social and emotional needs. The gaps in skills and confidence found among some respondents, and the organisational and professional cultures which actively avoid dealing with sensitive family issues highlights the need for ongoing support structures. Sources of ongoing support could include:

- A dedicated CAARS website where practitioners could access all main documents including the user guide. This could also include an interactive online facility where practitioners can post questions about CAARS or request to be contacted from ARACY staff.
- Topics that need to be covered in ongoing support/training include how to seek consent from families, how to work with families and how to collaborate with other professionals.
- Engagement with professional peak bodies and training institutions to assess their views about improving training and support for key universal professionals around engaging more holistically with children and families, and providing the skills and supports for practitioners to respond appropriately.
- Training modules and materials to be developed for strategic and middle managers to engage them in supporting CAARS.

CAARS governance

The model adopted for phase 2 of the development of CAARS consisted of the following key components:

- Implementation in specific geographical sites;
- Appointment of facilitators or 'champions' in each site;
- A 'cascade' model of implementation with ARACY training the facilitators who in turn trained practitioners locally and also engaged with local agencies; and
- Support for champions by ARACY.

The evaluation has identified a number of strengths and difficulties in this approach. It has certainly shown up the strengths and difficulties of CAARS itself, and has highlighted the need for a common approach amongst agencies. However it has also shown that the 'bottom up' approach has significant limitations. Without support by middle and senior organisational managers, locally as well as nationally, it is unlikely that CAARS can be sustained. This is because there are significant barriers to the implementation of CAARS even though there appears to be almost universal support for the basic notion of a common approach and of more holistic engagement with families.

It is also clear that the focus on geographical sites, although it makes sense in terms of multi-agency working, does not address all the issues underpinning the basic philosophy of the National Framework for Protecting Australia's Children (Commonwealth of Australia, 2009). A more strategic approach which focuses on professional training of key practitioners, organisational and professional cultures which eschew holistically engaging with families, and agency structures which provide barriers to early engagement are needed to provide the context in which CAARS can be successfully implemented.

Terminology

It became clear during the course of this evaluation that the name CAARS (Common Approach to Assessment, Referral and Services), although providing reasonable 'brand recognition' has caused a great deal of confusion about the nature of CAARS and its underlying principles. In particular, the terms 'assessment' and 'referral' are problematic as they denote a clinical and problem-centric approach to the provision of support. If CAARS is conceptualised as an 'approach' which, at its core involves practitioners engaging with clients more holistically and feeling empowered to discuss sensitive issues and either work with families to find solutions or refer appropriately, then there is almost universal agreement that this is appropriate and required. However the term 'assessment' implies, for many practitioners, particularly in the health sector, a validated 'tool' which can be used to quantify problems and assist in making clinical diagnoses. This puts CAARS in competition with a number of other, better established instruments, which, although much more narrowly focused, do provide more rigorous assessments.

The term 'referral' is also misleading because it undermines one of the basic principles of CAARS; that families should be empowered to address minor issues by engaging in 'normal' community activities such as sports, recreation and/or further educational opportunities, rather than being referred to secondary or indeed child protection services. CAARS is not a tool for mandatory reporters to assess the risk to children, but is often seen in that light. Being part of the Framework for Protecting Australia's Children (Commonwealth of Australia, 2009) adds to the confusion around this issue. CAARS' main value is not around prevention of abuse, but is much more holistic in its approach.

Training issues

Training and support needs to be provided and maintained not just in how to conduct a CAARS conversation, but also how to provide support for a child or family once a need has been identified. Evaluation of the UK's Common Assessment Framework (Brandon et al, 2006) found that this tool does not function as well when a problem is identified and passed on. The tool was found to be most effective when practitioners acquire an understanding of the child's needs and work out with the child and family, and sometimes other professionals, what extra help might be needed. To do this well, practitioners also need to be skilled in working alongside and involving families in both the assessment and supporting process. Skills training is required so that practitioners can be confident in seeking consent, working with families, and in dealing with other professionals.

6 Conclusions

This section of the report brings together the findings of the evaluation and draws out the implications of those findings. In the next section we make specific recommendations about the future development of CAARS. The conclusions address issues related to the CAARS tool and to the implementation of CAARS in the four sites.

Summary

The evaluation has highlighted a variable picture of implementation across the four trial sites. Much of this can be attributed to differences in site structures and services. The evaluation has found that CAARS is generally successful in its primary purposes of alerting practitioners to the needs of families with which they come into contact and facilitating a more holistic engagement with families which allows them to explore issues, work out solutions to minor problems and refer to appropriate supports for more significant issues. The findings are less positive in regards to facilitating collaboration between agencies and developing a common language around the needs of children and families, however, as shown in Table 3 below, these are long term project goals.

Table 3 highlights the trial's significant success in meeting short term outcome goals. Evaluation findings indicate that there is some supporting evidence for all short term outcomes, however, more positive practitioner outcomes were evident amongst secondary service practitioners. Evidence of the trial achieving longer term outcomes was not found, however, given the short term nature of the stage 2 trial and evaluation, this is not surprising.

Table 3: Trial Outcomes shown for CAARS Logic Model

Practitioner Outcomes	Child & Family Outcomes	System Outcomes
Short Term Outcomes		
Increased awareness of role in prevention YES	Improved relationship with practitioner SOME EVIDENCE	Increased number of practitioners identifying child/family needs earlier YES
Increased confidence and willingness in initiating conversations with clients YES BUT MAINLY SECONDARY SERVICES	Increased awareness of family situation and how it impacts on children SOME EVIDENCE	
Increased ability to identify families' strengths and needs YES BUT MAINLY SECONDARY SERVICES	Increased understanding of assistance available and potential benefit of pathways offered SOME EVIDENCE	
Increased level of support and follow up SOME EVIDENCE	Increased use of services/assistance to improve child wellbeing SOME EVIDENCE	
Changes in referral patterns SOME EVIDENCE		
Long Term Outcomes		
Increased collaboration between practitioners and between services NO SUPPORTING EVIDENCE	Increased empowerment and motivation to address children's needs SOME EVIDENCE	Increased number of practitioners preventing child abuse and neglect
Increased use of 'common' or shared language on holistic needs with other practitioners NO SUPPORTING EVIDENCE	Reduction in incidence of child abuse and neglect NO SUPPORTING EVIDENCE	Decreased demand for secondary and tertiary services NO SUPPORTING EVIDENCE
	Improved child wellbeing NO SUPPORTING EVIDENCE	

The CAARS tool

The CAARS tool is appropriate for its purpose. The range of materials is generally welcomed by practitioners, particularly the wheel. However there is consensus that the tools themselves can be significantly improved, particularly by consolidating materials, reducing duplication and simplifying the language.

Although most participants believed that the tool could be improved and simplified, this is unlikely to be easy to achieve. There is no consensus about which aspects of CAARS should be maintained, and different practitioners use different components of CAARS. A number of participants also pointed out that CAARS should be expanded to better address the needs of Aboriginal and Torres Strait Islander and CALD families as well as other groups, and suggestions were also made for the development of questionnaires specifically aimed at children and people with low levels of literacy. In addition some practitioners advocated the addition of specific questions relating to their area of work (for example around sleeping patterns). All these suggestions point towards a more complex rather than a simpler tool. The ideal would be a 'core' tool which could be adapted by practitioners for specific client groups and practitioner or agency needs.

Clearly this will take a great deal of thought and is likely to have to be done in incremental stages rather than a one-off redevelopment of the tool.

Implementation issues

The interviews highlight inconsistencies of use across sites as well as differences in professional competence. The success of CAARS is dependent on local approaches to implementation. This is why exploring the implementation of CAARS at the local level has provided clear guidance about improving practice and agency structures and processes. There is now a great deal of empirical evidence about the conditions for effective implementation of initiatives such as CAARS. Many of these prerequisites were not met in this phase of implementation. Nevertheless CAARS was taken up and used by a range of practitioners in all sites. Where it was not used, this was generally because of institutional barriers (for example, not being part of the Medicare Benefits Scheme) or because it was seen to overlap with existing assessment tools. There was general agreement that the basic philosophy underpinning CAARS is appropriate but that the next phase of implementation of the CAARS tool requires a more strategic and planned approach.

Health practitioners appeared to be those least engaged with CAARS. A particular issue for some primary health professions is that they already use other assessment tools with families and thus CAARS is seen as duplicating current work processes. This indicates that some sites were not 'implementation ready' and that before CAARS is implemented in a site or an organisation, an assessment needs to be undertaken about how CAARS will fit into current work practices, and whether there is the 'buy in' of senior managers. This should ensure better targeting of practitioners.

One of the most worrying findings of this evaluation was the range of practitioners who actively avoid engaging in discussions of sensitive issues with children and families. In some cases this is because of time pressures or other practicalities, but others were uncertain as to how to respond when they did uncover issues of concern. Some practitioners felt that it was not part of their professional remit to engage with families in this way. The implications of this finding for vulnerable children and families are potentially very severe. If children and parents feel unable to discuss sensitive issues with professionals who they trust, then many of them are likely to be reluctant to seek help until the situation becomes a crisis, in which case children are much more likely to need tertiary services. This finding shows the need for significant culture change in a number of agencies and for a range of professionals. It also shows that front line practitioners need access to support if they are to carry out their responsibility to protect children. Training needs to focus on the broad needs of families and not be focused exclusively on mandatory reporting.

There is potential for CAARS to be used more strategically, for example use of aggregated CAARS data by organisations or inter-agency committees to better understand the needs of families. In order for this to be possible there should be further development of data collection tools. This could be

undertaken by ARACY and become part of the suite of products related to CAARS, or agencies could adapt existing data collection processes to include information from CAARS conversations. However data collection should not add to the bureaucratic burden on practitioners and should only be undertaken if it is used to feed back to practitioners and improve practice.

Training

There is a clear need for ongoing training and support to build the confidence and capacity of practitioners in engaging holistically with families and to raise their confidence in addressing sensitive issues for families.

There is a need to ensure some aspects of training are standardized to ensure a degree of fidelity to the instrument – to ensure the ‘commonality’ of CAARS. This is important because one of the objectives of CAARS is to facilitate the development of a common language. In order to do so there needs to be a relatively high degree of consistency of approach by different professional groups in different sites.

Inter agency collaboration

The assumption that a common instrument would in itself facilitate responsibility sharing is not borne out by the findings of this study. Indeed, there were numerous examples of practitioners actively resisting a child welfare role. There were also structural barriers to inter agency collaboration in some sites. This phase of implementation was not resourced to address the strategic issues around implementation. If these are not dealt with in the next phases of CAARS development then it is likely that CAARS will become just another product which will be used in some organisations and by some practitioners. Although this would be valuable, it would not further the strategic aims of the National Framework for Protecting Australia’s Children (Commonwealth of Australia, 2009), which involve a fundamental shift in priorities and culture within universal services.

Further roll out

It is challenging to identify successful strategies for a national rollout from the trial evaluation because each site was so unique, however, some strategies were successful, in particular the ongoing support by ARACY and the training provided to site champions. Commitment to CAARS from senior and middle managers was a significant facilitating factor to implementation. This will need to be carefully assessed in preparations for roll out to further sites. It appears that more effort could be devoted to assessing the implementation preparedness for sites prior to their being selected.

7 Recommendations

The following recommendations arise out of the conclusions from the formative evaluation of CAARS. The main intention of the recommendations is to better facilitate a wider roll out of CAARS.

Refine the CAARS instrument

- Simplify language where possible.
- Consolidate materials and avoid duplication.
- Provide online 'soft' versions of the tools.
- Improve data collection facilities.
- Adapt the materials to better meet the needs of Aboriginal and Torres Strait Islander and CALD families and those with limited literacy.
- Provide more detail on the underlying approach and rename to remove the focus on assessment and referral.

Target specific practitioner groups for CAARS implementation

- If being implemented in specific sites, identify other tools which are already being used and assess the added value of CAARS.
- Focus on early years professionals and other universal providers, rather than secondary service practitioners who generally work with families with multiple and complex problems and whose needs extend beyond the realm of early intervention.

Provide ongoing training and support

- Training to be directed towards the needs of universal providers.
- Training to address the issue of practitioners' reluctance to encourage children and/or families to disclose information that indicates that children are in need of protection from abuse or neglect or the risk of these occurrences.
- Training and support for practitioners to raise their confidence in helping families with a range of problems to address those issues or to agree to access other services.
- Follow up should be provided to practitioners shortly after initial training.
- Provide an online support and training module and interactive facility for practitioners using CAARS.

Workforce issues

- Align CAARS with relevant child and family service workforce development initiatives, either as part of the National Framework for Protecting Australia's Children (Commonwealth of Australia, 2009) or as part of state and territory developments.
- Engage with peak bodies and professional organisations to ensure that training, professional development and guidance support holistic engagement with children and families.

Role of ARACY

- Continue to provide support and a central focus for the development and roll out of CAARS.
- Work with FaHCSIA to engage strategically with professional bodies and training institutions to facilitate a common approach to child wellbeing and protection.
- Work with agencies and other organisations to roll out CAARS in a range of contexts, not only geographical sites.

Further research

More work needs to be done to transform the organisational and professional culture of practitioners, services and sectors who do not view child protection as their concern. CAARS is a valuable instrument to help promote a culture of universal responsibility. Further research is needed into the reasons why some professional groups are actively opposed to take on this role, even though they value CAARS in principle.

8 References

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Appendix A: Ethics approval



31 October 2011

Professor Ilan Katz
Social Policy Research Centre

Dear Professor Katz

**Preventing child abuse and neglect through a Common Approach
to Assessment, Referral and Support (CAARS), Stage 2**
HREC 11319

Thank you for the email and attachments to the Mrs Annamarie Dsouza dated 11 October 2011.

The Executive of the Human Research Ethics Committee considered the above protocol at its meeting held on 25 October 2011 and is pleased to advise it is satisfied that this protocol meets the requirements as set out in the National Statement on Ethical Conduct in Human Research*.

Having taken into account the advice of the Committee, the Deputy Vice-Chancellor (Research) has approved the project to proceed.

Would you please note -:

- approval is valid for five years (from the date of the executive meeting i.e. 25 October 2011);
- you will be required to provide annual reports on the study's progress to the HREC, as recommended by the National Statement;
- you are required to immediately report to the Ethics Secretariat anything which might warrant review of ethical approval of the protocol (National Statement 3.3.22, 5.5.7) including:
 - a) serious or unexpected outcomes experienced by research participants (using the Serious Adverse Event proforma on the University website at http://www.gmo.unsw.edu.au/Ethics/HumanEthics/InformationForApplicants/ProformasTemplates/C13_SAE%20Proforma.rtf);
 - b) proposed changes in the protocol; and
 - c) unforeseen events or new information (eg from other studies) that might affect continued ethical acceptability of the project or may indicate the need for amendments to the protocol;
- any modifications to the project must have prior written approval and be ratified by any other relevant Human Research Ethics Committee, as appropriate;

..1..

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(HREC 11319 cont'd)

..2..

- if there are implantable devices, the researcher must establish a system for tracking the participants with implantable devices for the lifetime of the device (with consent) and report any device incidents to the TGA;
- if the research project is discontinued before the expected date of completion, the researcher is required to inform the HREC and other relevant institutions (and where possible, research participants), giving reasons. For multi-site research, or where there has been multiple ethical review, the researcher must advise how this will be communicated before the research begins (National Statement 3.3.23 and 5.5.6);
- consent forms are to be retained within the archives of the Centre and made available to the Committee upon request.

Yours sincerely,



Professor Michael Grimm
Presiding Member
HREC

*<http://www.nhmrc.gov.au>

Appendix B: Semi-Structured Interview Guide

Interview Schedule for stage 2 fieldwork⁶ CAARS Evaluation

Questions for practitioners using the CAARS instruments

About you and your organisation

- Can you tell me a little about your workplace? What does your organisation/agency do?
- What is your role within your workplace?
- Can you tell me a little about your daily work? What do you do?
- Does your organisation/agency currently use any tool other than CAARS with vulnerable families to help identify what supports or services may be needed?
 - o If yes, how does CAARS fit in with existing tools used by your organisation/agency?

About training for CAARS

- Have you received any training to use CAARS? If yes, can you comment on the training you received.
 - o Who provided the training?
 - o What was it like? (e.g. group session, one to one, role play etc)
 - o What did you think of the training?
 - o After receiving the training did you feel confident to use CAARS?
 - o Is there any further training that you would like to receive?

About the CAARS materials and conversation

- What do you think of the CAARS approach to helping vulnerable children and families (e.g. speaking to families about possible problems)?
- Has CAARS changed the way you think about clients and/or interact with them? Has CAARS changed the way you make referrals? Did you provide the client with information?
- What do you think of the CAARS materials?
- How do you think CAARS fits in with your daily work? Is there a need for CAARS in your daily work? Which specific materials do you see a need for?

⁶ Updated 5 March 2012

- How do you think CAARS fits in with what your organisation does? Is there a need for CAARS within your organisation? Which specific materials?
- Have you used the CAARS materials yourself with clients? If no, why not. If yes:
 - o How many times have you used CAARS?
 - o Which materials have you used?
 - o Who did you use CAARS with?
 - o Were the materials helpful? Easy to use?
 - o Do you feel you had enough training and/or information about the materials to use them confidently?
- We are interested in the process of using CAARS. Can you tell me how you initiate a CAARS conversation and what happens from there?
- Did you give the family/child any of the CAARS materials to take home? E.g. questionnaire or wheel pad? Was this before your conversation or after?
- Has CAARS been successful in helping you identify the needs of client families or children? Why or why not.
- After using CAARS, did you make any referrals? What was the outcome of the conversation? Did you provide any further help to the client or encourage them to take specific action? Did you refer to universal or targeted services or another practitioner?
- Do you know if any referrals made were followed up by the family and/or child? Did you follow up these referrals?

About the clients

- What can you tell me about the clients that you have used the CAARS materials with? (e.g. approximate numbers, family/client type, problems experienced by families, concern you had about these families).
- How do you decide which clients to have a CAARS conversation with?
- Are there any specific client types that you think the CAARS materials are suitable or unsuitable for? How so? Which materials?

Questions that will help in refining the CAARS material

- If you have used the CAARS materials: can you discuss the main facilitators and barriers that you have come across in using the CAARS materials with families and/or children?

- If you have not used CAARS materials: can you discuss the main barriers that you have come across in attempting to use the CAARS materials with families and/or children?
- Which materials worked/which didn't? Did some materials work better in some circumstances and some in others?
- What would you change about the CAARS material if you could?
- What do you think about the look and feel of the materials?
- We are interested to know how you are talking about CAARS. What language do you use to describe CAARS - the process and the materials? How do you describe CAARS to clients and/or other colleagues?
 - o E.g. conversation, assessment, tool, dialogue etc

Primary intervention

- CAARS has been developed and marketed as a tool to identify areas where families may need some additional help, generally below the threshold of child protection interventions. Is the possibility of identifying a child protection issue one of the barriers to using CAARS from your perspective?
- Child protection in Australia is increasingly using a public health approach. This is where all services and organisations, even if they don't have a child protection focus, have a role to play in identifying the needs of children and working to prevent child abuse and neglect, this is called 'primary intervention'. We are seeing if CAARS is one way to do this.
 - o What do you think primary intervention looks like?
 - o How do you think primary intervention could be used in your daily work or organisation?
 - o Can you think of an alternative to CAARS that would achieve primary intervention in your work for children and families?

Collaboration with other child and family services

- How closely do you work with other services/agencies in meeting the needs of client families and/or children? How often do you collaborate with other services/agencies?
- Has CAARS changed the way agencies work together in your local community?

Questions for Non-Users

About the training for CAARS

- Can you comment on the training you received for CAARS?
 - o Who provided the training?
 - o What was it like? (e.g. group session, one to one, role play etc)
 - o What did you think of the training?
 - o After receiving the training did you feel confident to use CAARS?
 - o Were you followed up after training, or did you feel that they had someone to talk to about your difficulties or apprehensiveness using CAARS?
 - o Do you feel that further training may change your mind about using CAARS?

About decision not to use CAARS

- Why have you chosen not to use CAARS? (or, why are you hesitant to use CAARS?)
- Have you trialled using CAARS with any clients? If no, why not. If yes-
 - o Who were these clients?
 - o How did this conversation go?
 - o What materials did you use?
 - o How did this influence your decision to not use CAARS with clients in the future?
 - o Was there anything in particular about the materials that made you decide that you wouldn't use CAARS in the future?
 - o Was there anything in particular about the CAARS process or conversation that made you decide that you wouldn't use CAARS in the future?
- Are you already using another tool to talk with families? How is this tool better than CAARS?
- What specifically is it about CAARS that has made you decide not to use it?
- Do you think CAARS is inappropriate for your organisation/ practitioner group as a whole, or do you just think that it is not right for you individually?
 - o Reasons?

- Was there any support from management or amongst your colleagues in your organisation to use CAARS?
- What are the particular barriers to using CAARS?
 - o Time constraints;
- CAARS has been developed and marketed as a tool to identify areas where families may need some additional help, generally below the threshold of child protection interventions. Is the possibility of identifying a child protection issue one of the barriers to using CAARS from your perspective?
- Child protection in Australia is increasingly using a public health approach. This is where all services and organisations, even if they don't have a child protection focus, have a role to play in identifying the needs of children and working to prevent child abuse and neglect, this is called 'primary intervention'. We are seeing if CAARS is one way to do this.
 - o What do you think primary intervention looks like?
 - o How do you think primary intervention could be used in your daily work or organisation?
 - o Can you think of an alternative to CAARS that would achieve primary intervention in your work for children and families?
- What improvements can you suggest for CAARS?
 - o Would these improvements increase your likeliness to use CAARS in the future?

Appendix C: Interview Coding Frame

Preventing child abuse and neglect through CAARS, Stage 2 Coding framework for interviews with Champions and Practitioners

Organisation / site	Respondent's role	ORG-RES	Information on respondent's role within organisation/agency and why volunteered to be site champion
	About the organisation/ agency	ORG-ROLE	Information on what the organisation does
	About site/ the community	ORG-COMM	Information on the site and community context.
	Other tools within site	ORG-TOOLS	Information on other tools used within site and how they fit with CAARS.
	Collaboration	ORG-COLLAB	Information on how sites collaborate with other agencies and if CAARS has resulted in any change.
CAARS Training	Training provided by ARACY	TRAIN-ARACY	Information on training provided by ARACY (to site facilitators) including suggested changes.
	Training provided at sites	TRAIN-SITES	Information on training provided to practitioners and others at the sites, including suggested changes.
CAARS Trial	Facilitators for use	CAARS-FACILITATORS	Information on factors that facilitate use of CAARS within sites.
	Barriers to use	CAARS-BARRIERS	Information on factors that restrict use of CAARS within sites
	Different professions	CAARS-PROFESSIONS	Information on whether CAARS materials fits with particular roles, professions etc.
CAARS Materials	Materials	CAARS-MATERIALS	Information on specific CAARS materials e.g. wheel, questionnaires, conversation prompts etc.

	Process	CAARS-PROCESS	Information on process of using CAARS with families or children. (e.g. easy, helpful, long, etc)
	Referrals	CAARS-REFERRALS	Information on any referrals made during CAARS conversation e.g. who to? Did you follow up etc.
	Information	CAARS-INFO	Is information provided through CAARS package enough? Useful? Etc. Is more information required?
	Changes	CAARS-CHANGES	Any suggested changes to CAARS materials.
	Language	CAARS-LANGUAGE	Any information about language sites/ARACY use to describe CAARS.
	Uses	CAARS-USES	Any data about how the tools are being used eg. in men's groups
	Appropriateness	CAARS-APPROP	Any data about the materials being particularly appropriate or inappropriate for particular groups or in particular situations
General Feedback	Practitioners	CAARS-PRAC	Any general comments from practitioners, either directly or indirectly, about the tools
	Clients	CAARS-CLIENTS	Any general comments from clients, either directly or indirectly about the tools
	Facilitators	CAARS-FAC	Any general comments about the tools from site facilitators
CAARS-ARACY	Role of ARACY	CAARS-ARACY	Any information about the role of ARACY and supports provided to trial CAARS.
MISC	Miscellaneous	CAARS-MISC	Any useful information not coded anywhere else

Appendix D: List of practitioners and organisations trained to use CAARS

Practitioners trained to use CAARS

	Adelaide	Gippsland	Lismore
school teachers		1	
school support/ executive staff	8		
school counsellors	8		
early childhood education and care staff	9	7	22
Child family and support workers- community based	14		
Social workers- community based	16		
Social workers- hospital based	5		
Mental health workers- community based	11		
Mental health workers- hospital based	2		
Various hospital staff- managers, midwives, nurses	37		
Aboriginal mental health workers	4		
Midwives- community based		7	
Various staff- Facilitating organisation, ie. Northern Connections Adelaide, Interrelate Lismore, Gippsland Lakes Community Health Service, RKDGP		15	23
Drug and Alcohol workers- community based	7		
Counsellors			
Case workers			5
Legal practitioners	1		8
Total*	122	30	58

*The total number of practitioners trained in the Rockingham Kwinana site was not recorded, however they are listed below.

Adelaide	
<u>Organisations engaged</u>	<u>Role of practitioners</u>
<p>Adelaide Northern Division of General Practice Anglicare Child and Family Health Services Craigmore High School Dept for Education and Child Development, Northern Adelaide Regional Office Drug and Alcohol Services SA Elizabeth Elizabeth Fremont City High School Elizabeth Grove Children’s Centre Elizabeth Park Schools Goodstart Early Learning Paralowie West Goodstart Early Learning Salisbury North Headspace John Hartley School Elizabeth Plains Kuarna Plains School Lyell McEwin Hospital Para West Adult Campus Davoren Park Playford Primary School Swallowcliffe Schools</p>	<p>Aboriginal mental health workers Assistant School Principals Child and family support workers Child health nurses Community Development Coordinator ECEC centre directors ECEC workers Family Clinic nurses Mental health clinicians Midwives Paediatric Nurses Perinatal Mental Health Clinicians Personal Helpers and Mentors Program (PHAMS) workers School counsellors Social workers Student support workers Youth workers</p>

Gippsland	
<u>Organisations engaged</u>	<u>Role of practitioners</u>
<p>Bairnsdale Regional Health Services GLCH Family Youth & Children’s Service (FYCS) Swan Reach Pre-School</p>	<p>Early Childhood Development worker ECEC centre manager ECEC workers Intake, assessment and response staff Maternal and Child Health Nurses Midwives</p>