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Keeping children safe in out of school hours care. Perceptions of staff and managers of one provider in Sydney, Australia.

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This study explored perceptions of child abuse and child protection matters involving staff working in the Out of School Hours Care (OSHC) sector. Quantitative and qualitative data were collected through an online survey, focus groups and interviews with staff and managers employed by one organisation that provided OSHC services in Sydney, Australia. This paper reports on their perceptions about implementing mandatory reporting requirements associated with the concepts of 'significant harm' and 'reportable conduct'. The aim of this paper is to engage OSHC stakeholders, including Government, in reviewing child protection policies and practices to support educators in their work with children. Key findings indicate the inadequacy of available training, and the importance of relationships and communication between stakeholders, especially OSHC and school staff. This requires systemic change including raising the status of OSHC and the critical role these educators have in supporting children's development, learning and wellbeing during the early years of school.

Keywords: child abuse; child safety; mandatory reporting; outside school hours care; schools

- leadership to support educators to engage in respectful partnerships for child protection with families and schools to ensure children's well-being and learning outcomes.
- training on supporting children's safety and well-being in OSHC is critical.
- Need for a systems approach to OSHC services which places children's development, learning and wellbeing at the forefront of professional practice.

Setting the context

Out of School Hours Care (OSHC) services in Australia provide children aged five to twelve years with play and recreation programmes during the periods: before school, after school, and during vacations (Simoncini et al., 2015). Sheppard (2015, para 4) notes that according to the Australian Bureau of Statistics (ABS) data "for school-aged children, OSHC was the main source of formal care, with 13 to 17 per cent of children aged 5-9 years accessing care". Across Australia, over the years, these services have continued to increase: in 2019 there were 4,466 OSHC services (ACECQA, 2019) in comparison to 2,256 services in 2006 (AGDE, 2006).

Over the last decade, national policy reforms in Early Childhood Education and Care (ECEC) in Australia have emphasised the importance of child protection as one element of enhancing quality service provision for all children (ACECQA, 2018). Today, OSHC services are required to participate in the quality rating and assessment process, and implement the *My Time, Our Place Framework* (DEEWR, 2011), as well as the *National Quality Standard* (NQS) section 2.2 to ensure "each child is protected" (ACECQA, 2018). The NQS is however predominantly focussed on services for children under five years. As a consequence, the application of the NQS within OSHC potentially creates confusion as these services cover children aged 6-12 years.

Public attention, stemming in part from the Royal Commission's inquiry into *Institutional Responses to Child Sexual Abuse* (Saunders and McArthur, 2017), has heightened sensitivity towards issues of child protection and mandatory reporting requirements throughout Australia. Essentially, this inquiry reported on the failure of the child protection systems and the need for a review of mandatory reporting processes (Commonwealth of Australia, 2017). The UNICEF Australia report (2018) on the experiences of Australian children also highlighted the lack of accurate national data on child abuse and neglect. This report further indicated that child protection staff were not able

to accurately measure the risk of violence that might be experienced by children and young persons. In the case of institutional abuse, there was a need "to address the situational contexts that make institutions inherently unsafe environments for children" (p.26). Mandatory reporting and institutional safety are related but separate matters and are often confused by staff in both early childhood and school settings. Our study was aimed at exploring these perspectives among those involved in OSHC services run by one organisation in the State of New South Wales (NSW).

Under national policy, 'responsible people' must be identified within each service to oversee compliance requirements on child protection and hold the Certified Child Protection (CP) qualification. Training on child protection matters often targets educators in early childhood services catering for children from birth to five years. There are no specific requirements for training or qualifications on child protection for an OSHC educator or a manager. Therefore, unless the educator has a Diploma of School Age Education and Care, which includes child protection training, the onus is on providers or employers to ensure staff are aware of the child protection law and their responsibilities.

The administration of the national policy rests with each state and territory government. In NSW, the relevant legislation is captured in the Children and Young Persons (Care and Protection) Act 1998, and the Children Legislation Amendment (Wood Enquiry Recommendations) Act 2009 (https://www.legislation.nsw.gov.au/acts/2009-13.pdf). According to this legislation, 'significant harm' can also relate to neglect, on the basis that "the child's or young person's basic physical and psychological needs are not being met" (Children and Young Persons (Care and Protection) Act 1998, p. 28 and the Children Legislation Amendment (Wood Enquiry Recommendations) Act 2009). 'Significant harm' can also relate to children or young persons who: a) have been abused or are at risk of being physically or sexually abused; b) are living in situations of domestic violence, c) are at risk of serious psychological harm; and d) where there are concerns for the wellbeing of an unborn child (Children and Young Persons (Care and Protection) Act 1998).

In Australia, child protection requirements are defined by law in terms of the principle of 'mandatory reporting' in two key ways. First, OSHC educators must report to the relevant state/territory authorities any reasonable suspicions they have that a child might be experiencing 'significant harm' including within the family, the OSHC setting or in circumstances external to the OSHC setting. Reporting is based on the grounds that the incident/s arose during the course of the OSHC educator's work (see section 27 of the Children and Young Persons (Care and Protection) Act 1998: https://www.legislation.nsw.gov.au/acts/1998-157.pdf). Second, OSHC educators are required to protect children from harm by those in the workplace. Where educators, managers or other staff are harming children, this is called 'reportable conduct' under the Ombudsman Act and such cases must be reported to the state Ombudsman's Office (Ombudsman NSW, 2017).

In Australia, during 2014-2015, one in 35 children and young people between the ages of birth to 17 years (n=151,980) were reported to child protection services. Most of these reports (73%), related to emotional abuse and neglect and included high numbers of repeat clients (Australian Institute of Health and Welfare, 2016). In NSW, schools and childcare staff made 14% of these reports to the Department of Community Services (n=10,278), with 1.2% of these being made by childcare staff. It is not clear how many reports were completed by OSHC staff and we contend that data should represent these services more explicitly. The absence of a nationally coordinated approach to managing mandatory reporting and child protection processes across Australia (AIHW, 2018) and inadequate training for educators (Walsh et al., 2011, Ey et al., 2017) are concerning. The UNICEF Australia Report (2018, p. 17) also noted "a lack of tools and approaches to engage children in decisions was a 'large gap in almost all child protection frameworks' across Australia".

What does the research say?

There is scant literature on child protection matters within OSHC. In 2018, conducting an advanced search of literature using the key words 'children', 'child protection' and 'outside school hours' and 'school aged children' yielded a total of 26 papers. These consisted of four grey reports (Griffiths, 2013, Kenny, 2000, MCEECDYA, 2011, Network of Community Activity, 2013), two Australian PhDs on OSHC not specific to child protection (Simoncini, 2010, Cartmel, 2007), and 20 peer reviewed research studies. Of these peer reviewed studies, two articles reported on a randomised control trial (RCT) study on child protection matters that did not include OSHC educators (Matthews et al. 2015, 2017), and seven articles focussed minimally on OSHC educators (Cossar et al., 2016, Dewhirst et al., 2013, Goebbels et al., 2008, Goldman and Grimbeek, 2014, Johnson, 2008, Sanders and Pidgeon, 2011, Walsh et al., 2011) .

Only seven of the peer reviewed articles targeted OSHC, with five exploring workforce participation and quality (Winefield et al., 2011, Simoncini et al., 2015b, Cartmel and Grieshaber, 2014, Cartmel and Brannelly, 2016, Cartmel and Hayes, 2016) and two reporting on one study that surveyed educators (26=OSHC, 8=preschool, and 73=primary school) on their understandings of normal and problematic sexualised behaviour and training needs (Ey and McInnes, 2018, Ey et al., 2017). Of the four scholarly literature reviews, two were conducted in Australia (Briggs, 2014, Scholes et al., 2012), one in the UK (Featherstone et al., 2013) and the USA (Durlak et al., 2010).

In sum, there was minimal scholarly literature, including evidence-based research focusing on reportable child abuse and protection matters involving OSHC services in Australia. However, fostering child protection in the early years is critical as indicated by previous research conducted by those such as Efevbera and colleagues (2017), McInnes and Ey (2019) and Richter and colleagues (2017). While adults working with children across educational sites are required to report on suspected instances of child abuse and neglect (AIFS, 2017), there is a lack of research involving OSHC.

Research on child safety and abuse prevention highlights the importance of educators, social workers and other professionals working with families to ensure child and family well-

being (Cocks, 2018). In focusing on family inclusion, Cocks (2018) recommends that focusing on the "social causes" of abuse is paramount in creating evidence-based supportive practices. Others suggest there is a "need for respectful, relational practice in child protection with children and their parents" (Bain et al., 2017, para. 5). These aspects confirm the importance of communication in dealing with child protection and that keeping children safe is a community concern. The number of OSHC services in Australia is expanding and these play an important role in supporting children and families due to parents' paid employment, training or study commitments. Conducting research on child protection by capturing the perspectives of the OSHC sector is essential in establishing systemic reforms.

Research design, data collection and analysis

Our study was conducted during July 2017 to June 2018, supported under the Enterprise Partnership Scheme at Macquarie University. It focused on identifying the perceptions and understandings of child abuse and protection in OSHC settings by staff and managers employed by Primary OSHCare. The research questions included:

1. What are Primary OSHCare educators' and managers' understandings of child protection?

2. What are Primary OSHCare educators' and managers' perceptions of child abuse and neglect?

For the purposes of this study, employees who worked directly with children as educators and assistant coordinators, were defined as primary contact staff. All others, including service coordinators, were defined as managers and may or may not be on the premises daily.

In NSW, OSHC service management structures include small or large organisations (which could be for profit or not for profit), the school's parent management group, and/or local municipal government. In NSW, and nationally, only 16% of all OSHC services have been approved under the NQS as exceeding in quality service

provision (ACECQA, 2018). At the time of this study, Primary OSHCare operated 40 services with 20 (50%) rated as exceeding quality standards. Thus, it can be argued that at that time, Primary OSHCare had a strong public profile as a quality provider.

During the period of data collection, Primary OSHCare had 3600 children attending each day and employed 275 staff. The organisation had clear induction processes for all new staff, including casuals completing professional awareness and behaviour training covering children's safety and signing the company's Code of Conduct. Those identified as 'Responsible People' also attended specific training which outlined their responsibilities under the Law. The organisation also had a designated Child Protection Officer, who supported staff with reportable incidents, and there were clear lines of communication for managing child protection matters.

There were two phases in our study: Phase 1 consisted of an anonymous online survey completed by educators and managers; Phase 2 involved focus groups and 1:1 interviews. Drawing on the literature reviewed, there was a mix of open and closed questions focusing on participants' understanding of key concepts such as: abuse, neglect, behaviour, strategies, and their experiences of strengths and barriers to reporting and managing child abuse allegations.

As indicated in Table 1, the survey was completed by 169 respondents, comprising 119 staff (99 educators and 20 assistant coordinators) and 50 managers (34 service coordinators, three regional coordinators, six regional managers, and seven professionals in other roles) representing a 61% response rate for the online survey. All responses (including partial responses) were coded and included in the analysis of both qualitative and quantitative data. Phase 2 consisted of one focus group (n=3) and interviews (n=2) with educators in two geographically distant services to ascertainpotential variations. Interviews were also conducted with key management staff (n=5) to understand the nuances of organisational processes including interagency sharing of reporting (see Appendix X for the focus group/interview questions and how they mapped to the research questions).

INSERT TABLE 1

The study was approved by the Macquarie University Human Research Ethics Committee (Study ID: 5201700724). Staff and managers were advised that participation was entirely voluntary and they were free to withdraw from the study at any time without explanation and without jeopardising their employment. Surveys were open to all employees, completed online and retrieved directly by the researchers. There was no identifying information collected in the data in terms of participants' names and other personal details. Interviews and focus groups were conducted by a research team member at a mutually convenient time during working hours and participants were de-identified in the data analysis.

The study was approached as an explanatory sequential design (Creswell and Plano Clark, 2011) comprising quantitative and qualitative data collection and analysis to explore the complexities of child protection and safety. Phase 1 quantitative data were analysed using the statistical programme, SPSS 24. Frequencies are expressed in percentages and used to illustrate broad patterns across the full dataset. The qualitative methods (Phase 1 open-ended questions and Phase 2 focus groups and interviews) allowed for deeper understandings of the contextual factors and a phenomenological approach was applied with the assistance of NVivo 10. The analysis was iterative, drawing on elements of thematic analysis (Braun and Clarke, 2006) and included inductive and deductive analysis of participants' understandings of child protection.

Findings

The presentation of findings begins with participants' demographics, followed by an examination of findings that emerged under two main themes: 1. Keeping children safe; and 2. Importance of relationships and communication channels.

Participants

Study participants were predominantly young adults new to the OSHC workforce. For instance, over half (68%) of the participants had worked in the sector for less

than three years, which included nearly one third (28%) working less than one year. The majority (66%) were aged 21-30 years and 12% were below 20 years of age. Approximately 4% had not completed high school, while 27% had achieved the High School Certificate (secondary education to year 12) as their highest qualification. Of the others, 34% had an early childhood qualification and this was comprised of 14% with a Certificate III (six-month vocational qualification); 15% held a Diploma in Children's Services (two-year vocational qualification) and 5% had a Bachelor Degree in Early Childhood Education (four-year university qualification). A further 35% of participants held a qualification other than an Early Childhood qualification.

Theme 1 - Keeping children safe

Question 3 of the survey was open-ended and asked participants to identify the most important aspects of their job, and participants could record more than one response. Responses were sorted into key themes and analysis of these data revealed that staff highlighted the most important role as ensuring children's safety (/span>75%). Responses commonly included: "Ensuring children are safe and enjoying themselves is my number one priority" (Educator#SP102). Others noted looking after children (58%) and the importance of supervision of children (31%). For instance: "Keep constant surveillance on them to make sure they're always safe in the activities they take part in, and don't create any dangerous situations for themselves" (Educator#SP137).

Within both phases, participants described their role as involving a 'duty of care' emphasising the 'legal and moral' obligation which required reporting any reasonable suspicions of abuse and/or neglect. For instance: "It is a requirement of the job, keeping children safe should be the number one priority" (Educator#SP137). This perspective was reinforced by managers in senior roles, for example:

> They need to know that by inaction on their part, a child may be subject to abuse of various types. This will negatively impact their life at this time and for the rest of their life (Regional Manager#SP127).

These responses reflect participants' awareness of child safety compliance matters, however, it is possible that participants' awareness of the focus of the study influenced responses.

Open-ended responses from the survey sorted into key themes revealed that participants recognised and identified situations or 'signs' of abuse and/or neglect comprising both the visible (e.g. physical) and invisible (e.g. emotional and psychological) nature of child abuse and neglect. Participants' perceptions also reflected a shared perspective on what was expected of them as educators or managers of Primary OSHCare. Most participants believed that educators in their service understood the processes either 'very well' (46%) or 'well' (35%) while the minority (19%) indicated that their service 'somewhat' understood the processes (Question 19). Notably, when participants were asked how they decide on when to report a case to their superiors, 18% indicated that they relied on their own professional autonomy or 'gut instincts' to guide them. For example:

> If I felt that something was a little off with a child (Educator#SP158).

When considering the responses of those in various roles (See Figure 1), educators and assistant coordinators felt the majority of staff in their service (87%) understood the process of reporting child abuse either 'well' (33%) or 'very well' (54%), with only a small proportion of staff (13%) noting they 'somewhat understood' the processes. However, those in leadership roles (service coordinators, regional coordinators/managers and other executive staff) reported that only 29% of staff understood the processes 'very well', 39% understood the process 'well' and 32% felt their staff only 'somewhat' understood.

INSERT FIGURE 1

The majority (96%) of the survey participants also noted they were not concerned about reporting suspected cases of child abuse (Question 17). This finding could have been influenced by the reporting processes within the organisation and the study itself. Most participants (62%) noted that in situations when an issue was identified at

the service: “It is told to the regional manager or coordinator” (Educator#SP108) and “Reported to supervisor, to be passed on” (Educator#SP109). This practice was reinforced in the focus group and interviewsipants highlighted the systematic hierarchy for reporting information and for managing or escalating cases. For example:

> They [coordinator and regional coordinator] will be the ones, that we just report to them what’s happened, because when it goes to someone, they exactly know what to do (Educator#PFG06).

Many of the participants noted that this reporting hierarchy could be frustrating. For instance, participants indicated not knowing what happened with the report in terms of the procedure, as well as what the ramifications were for the child and family involved in the allegation. One participant noted: “Perhaps a more detailed course about what happens once a report is made for those in management positions” (Coordinator#SPI7). The lack of staff’ knowledge about what happens following a report being made to a manager, denotes misunderstanding the importance of maintaining ongoing communication with and between staff involved directly with the child, including the school. This could be influenced by the competing interests in terms of privacy and confidentiality between OSHC and schools.

Approximately one quarter of the survey participants (educators/assistant coordinators, 22% and managers, 29%) indicated they wanted to learn more about child protection (Question 27). The key areas identified included supporting children’s behaviour (particularly where children are subjects of allegations in terms of child protection), unpacking “normal” sexualised behaviours, and engaging in genuine family partnerships to ensure child protection requirements are satisfied, whilst valuing and embracing diversity (e.g. cultural, social, economic, genders and sexuality, etc). Although participants emphasised the legal focus on child protection matters, the complexities of the interplay between stakeholders involved in these cases were beyond the scope of this study.

Theme 2 - Importance of relationships and communication channels

Primary OSHCare's publicity materials stated that:

> Primary OSHCare is a values-based organisation that promotes a culture of child safe practices and adheres to the National Principles for Child Safe Organisations as determined by the Australian Human Rights Commission. (http://www.primaryoshcare.com.au/).

The collaborative practices appear to be a valuable source of support and reflection for practitioners in this organisation. For instance, participants referred to the importance of having support from peer mentors, managers and the organisation as being key to their work with children's safety and protection. Participants noted how these 'mentors' supported them to understand child protection matters, raising or flagging concerns and escalating concerns as appropriate. Educators identified this support in terms of being informed and communicated with. For example:

> For me, working in this Service, it's a good experience because [x supervisors] are very open to answer the questions, help. (Educator#IP06)

Service coordinators and senior staff identified colleagues who they could rely on for support when making notifications and identified this as an important aspect of their workplace. For instance:

> I remember the first time I made a report I remember psyching myself up in the bathroom, I found it quite emotionally draining, I was really upset and then I made it and I had my assistant with me who's an exceptional human being and very supportive. (Regional Coordinator#IP04)

The data also reinforced the centrality of relationships with the school Principal in managing child abuse and protection in OSHC services. Participants noted that the bulk of child protection communications with school teachers were channelled through the Principal. They noted that child protection could be compromised due to difficulties or the lack of communication, especially with the Principal. For instance:

> We, again, let the Principal know, but she wanted less to do with the process as a whole and just had made a note that we were managing the scenario. In other services that I've

> worked in, the one where I was a coordinator, the Principal and I would meet every week and talk about child welfare. (Executive Officer#IP03)

> In some situations, we don't necessarily find out all the information prior to a child attending, or if something has happened at school, until it happens at afterschool care, and then we find out that so many things have happened before that. You know, if we were aware of those situations, we could have better advocated for that child or prevented. (Assistant Coordinator#FG08)

Survey responses also indicated that educators understood the need to be sensitive when approaching families when there was an allegation of abuse about their child or by their child. For instance: "You've gotta be really careful about how you speak to parents, especially when the first instinct I think for a lot of families is to panic" (Regional Coordinator#IP04).

Discussion and implications for policy and practice

The protection of children and prevention of abuse presents challenges to those working in OSHC services. This study highlights that while educators are cognizant of 'signs' of abuse there is also hesitation and insecurity in the practicing of child protection and this could be exacerbated by the diverse range of qualifications in OSHC, and the lack of requirements for qualified staff. Exploring the uncertainties, challenges and insecurities educators express with child protection matters through research-led professional development could support educators' perceived efficacy with these issues. Further research investigating the impacts of an organisation's cultures on OSHC educators' feelings of being supported, and efficacy in managing situations of child abuse, could yield insights for improving practice.

Differences in understandings of what constitutes abuse and neglect, complicate the processes of reporting and identification. Currently, mandatory reporters are required to make a report where there is suspicion 'on reasonable grounds' that a child is experiencing any form of abuse or neglect. The findings demonstrated that participants used their own personal judgement alongside factsheets and behavioural indicators to decide what was 'reasonable'. There appears to be some reliance on inherently

subjective appraisals in ensuring children's safety and wellbeing. Given the absence of empirical research involving OSHC services, there is scope to review indicators of behaviours and fact sheets being used. While there are also policy frameworks and practice guides on child protection for mandatory reporters (e.g. the Mandatory Reporter's Guide: https://reporter.childstory.nsw.gov.au/s/), there are incongruities in training and understanding among OSHC staff, including how to work with families. The study by McInnes and Ey (2019) also noted the need for more training for educators.

Winefield and colleagues (2011) noted that OSHC is often "forgotten" in the public discourse on children's education, tied to workforce participation rather than child development or wellbeing. Their research indicated that parents' choice of OSHC was concerned primarily with rather than service quality. Comparatively, families choosing schools and early childhood settings are often concerned with the broader aspects of well-being of their children and their happiness, with safety often being cited as a priority (Stewart and Wolf, 2016). In the absence of more recent research involving OSHC parents, our study contributes to raising awareness of the importance of keeping children safe in OSHC services. Collaboration between families, school staff and OSHC services, especially school principals, is critical. As Cartmel's (2007) PhD highlighted, relationships between principals and OSHC staff on the surface appeared amiable but were constrained by organisational structures as well as a lack of "collective identity" (p. iii).

This study has highlighted the need for revising current policies and practices in terms of managing child abuse allegations in regard to interagency collaboration between schools and OSHC services. As noted in recommendation two of the Royal Commission: Coordinating programme delivery at the national level could help ensure the quality and robustness of prevention programmes (Saunders and McArthur, 2017).

Listening to children's perspectives and enabling children's participation in decisions and policy affecting their lives is also an important contributor in developing effective policies and practices in keeping children safe (Commonwealth of Australia, 2017). As the children's(UNICEF Australia, 2018) report states, "children are

more likely to raise concerns in institutional environments that empower, listen and believe them." (UNICEF Australia, 2018, p. 17). While the importance of listening to children cannot be underestimated, it is however not the children's responsibility to reshape the agenda. It is a collective community responsibility to prioritise practices that ensure children's input is heard, believed and valued as research shows that partnerships between children, families, schools and OSHC professionals, increase children's safety (Ross et al., 2017).

The main limitation of this study was that it was conducted within one organisation and only included the perceptions of educators and managers who were aware of the study. To expand the generalisability of these findings, this study needs to be replicated with other OSHC providers and include a diverse cross-section of stakeholders, such as school principals, teachers, families, and children, as well as other health and welfare professionals involved with child protection. Participating services were located within the Sydney metropolitan areas and do not reflect the nature of OSHC provision in rural and regional areas. The extent to which size, management structure and location can impact on child protection issues also requires further investigation.

This paper can be used as a stimulus to engage OSHC services in reviewing policies and practices that influence programme development, staff training and decisions-making on managing allegations of child abuse sector wide. This research also supports the consolidation of expertise and professionalism within the OSHC sector, necessary in reforming policy as well as developing effective

models and resources for improving practice to ensure child safety in OSHC. This requires a systems approach involving the diverse OSHC stakeholders placing children's development, learning and wellbeing at the forefront of professional practice.

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