

Part 4: Major protective system elements

Chapter 7:

Preventing child abuse and neglect

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Key points

- Victoria has a strong infrastructure of universal services for infants, children and young people, including through maternal and child health, kindergarten and schools.
- While there are high participation rates for maternal and child health and kindergarten the most vulnerable children and families are often excluded from these services.
- There is a lack of definitive research and evidence linking universal services to the reduction of abuse and neglect, however, the Inquiry makes the assumption that increasing participation in universal services such as maternal and child health, kindergarten and schools, will have an overall impact on reducing abuse and neglect.
- Within the non-stigmatising nature of universal services there are further opportunities for preventative activities for vulnerable children and families.
- Antenatal services are well placed to identify and reduce the risks of child abuse and neglect.
- Parental alcohol abuse is a significant risk factor for child abuse and neglect.
- Further efforts to prevent child abuse and neglect need to include the:
 - targeting of future government investment in the early years to communities that have the highest concentration of vulnerable children and families;
 - provision of early support to vulnerable pregnant women and infants;
 - implementation of strategies to encourage greater participation by the families of vulnerable children in universal services;
 - examination of current funding and infrastructure arrangements for services such as kindergartens, maternal and child health services and community playgroups that operate in locations where there are high numbers of vulnerable children and families;
 - development of a consistent statewide approach for antenatal psychosocial assessment;
 - development of a universal parenting information and support program that can be delivered by maternal and child health services and schools in communities with high concentrations of vulnerable children and families, at key ages and stages across the 0 to 17 age bracket; and
 - development of a wide-ranging education and information campaign targeted to parents and caregivers for all school-aged children to prevent child sexual abuse.

7.1 Introduction

This Inquiry has been asked to develop recommendations to reduce the incidence and negative impact of child abuse in Victoria, with specific reference to the factors that increase the risk of abuse and neglect occurring, and effective prevention strategies. There are a number of definitions of prevention. The Inquiry has adopted the following definition.

Inquiry definition of prevention

Activities that enhance child wellbeing and reduce the likelihood of child abuse and neglect.

Drawing on public health concepts, it is common when talking about prevention to distinguish between primary, secondary and tertiary prevention activities. Head and Redmond (2011, p. 7) differentiate between prevention activities by suggesting that:

- Primary prevention reduces the likelihood or the development of a problem, and is generally linked to universally available services;
- Secondary prevention interrupts, prevents or minimises the progress of a problem at an early stage, and is thus targeted towards groups with greater risks or vulnerabilities through early intervention programs; and
- Tertiary prevention services focus on treating and halting progression of damage already done.

This distinction between service ‘tiers’ is also recognised in the public health approach, which has been discussed previously in Chapter 6.

Recognising their common use, the Inquiry has chosen to adopt the distinctions between primary, secondary and tertiary prevention strategies as articulated above, while recognising that it has some limitations. For example, schools can be seen as sites of primary prevention, as well as secondary and tertiary prevention in relation to child abuse and neglect. As such, this chapter will consider primary prevention activities, while Chapter 8 is primarily concerned with secondary prevention, and Chapters 9 and 10 will consider tertiary prevention.

This Inquiry definition of prevention recognises that the application of a preventative approach includes activities that enhance child wellbeing outcomes, as well as the absence of negative outcomes such as child abuse and neglect.

It is clear from the consultations held by the Inquiry that prevention of abuse and neglect remains a priority for the community. A submission to the Inquiry from Child Wise argued that:

... the biggest threat to children’s futures is abuse. It destroys lives and communities ... Child abuse affects everyone and therefore, it is everyone’s responsibility to take action to prevent abuse from ruining the lives of children (Child Wise submission, p. 2).

The complexities associated with the effective implementation of prevention activities are also widely acknowledged, and captured well by another submission to the Inquiry:

Ambulances do not prevent injury and death on the roads. Rather, the road toll has been effectively reduced by a mix of strategies including better road design, public awareness campaigns and better driver training. We need a change in paradigm from reacting to abuse and neglect, to preventing abuse and neglect (Parenting Research Centre submission, p. 5).

This chapter considers both the current efforts in relation to the prevention of child abuse and neglect (section 7.2), including population-based approaches and the role of the universal services system, and future opportunities to expand those efforts (section 7.3) through services provided early in a child’s life, services for school-aged children and adolescents, support services for parents, and the importance of the community environment.

The preventive impact of the law was considered by the Inquiry in Chapter 3.

7.2 Current prevention efforts

Efforts to prevent child abuse and neglect include strategies aimed at the whole community through mechanisms such as social marketing campaigns (for example, pool safety awareness campaigns and summer warnings about children left in cars in hot weather), as well as using universal services to reduce the risk factors associated with child abuse and neglect. This section will consider population-based approaches and the role of universal services.

7.2.1 Population-based approaches

A population-based approach seeks to affect the behaviours and attitudes of the population through the use of interventions such as information social marketing campaigns and interventions that address the causes of problems, in this case, the risk and protective factors outlined in Chapter 2 (VicHealth 2008, p.17).

Social marketing campaigns

Improving parenting skills is one way to prevent child abuse and neglect and the Inquiry has considered how good parenting can be enhanced at a population level. Unfortunately, as noted in the Parenting Research Centre submission, there is currently little or no evidence as to the effectiveness of public awareness campaigns related to parenting (Parenting Research Centre submission, p. 7).

Saunders and Goddard (2002, p. 1) note that, while the media can play a significant role in forming and influencing people's attitudes and behaviour, the effectiveness of mass media in the prevention of child abuse and neglect is debatable. On the one hand, the mass media has an opportunity to reach large numbers of people, but on the other hand media driven campaigns can be expensive and their impact is difficult to measure.

A broader sweep of recent social marketing campaigns might suggest that campaigns can be effective in influencing public knowledge and attitudes about issues such as work safety, drug and alcohol use, drink-driving, speeding and cigarette smoking, but it is also suggested that behavioural change can lapse when campaigns end (Saunders & Goddard 2002, p. 2). Saunders and Goddard conclude that, to be effective, mass media campaigns will need to be part of a broader prevention program that includes the provision of supports and services for all children and families.

This finding is reiterated by an Australian Institute of Family Studies literature review of social marketing campaigns directed to preventing child abuse and neglect. The review concludes that there is relatively little evidence regarding the effectiveness of social marketing campaigns in preventing or reducing child maltreatment but also notes that the empirical evaluation of social marketing campaigns is challenging. The review therefore suggests that any future social marketing campaigns that aim to address child maltreatment in Australia involve comprehensive evaluation and pairing mass media with a community-level strategy (Horsfall et al. 2010, pp. 23-24).

There is currently insufficient evidence to support social marketing campaigns focused generally on child abuse and neglect. However, in relation to deaths and injuries related to supervisory neglect there is evidence of success of social marketing campaigns that are focused on specific behaviours (such as safety of children near water, in driveways and ingesting medications). Such opportunities could be taken up by the proposed Commission for Children and Young People recommended in Chapter 21.

Matter for attention 1

The Inquiry draws attention to the opportunity in broader government-sponsored community awareness campaigns to include child-focused dimensions, for example, family violence campaigns. These campaigns could include the impact of family violence on the children and young people in the family.

Interventions targeting the cause of problems

A population-based approach also focuses on interventions that address the cause of problems. As noted in Chapter 2 there are a number of factors that are known to have a direct link to child abuse and neglect. Several of these factors lend themselves to a population-based focus, in particular family violence, alcohol and other substance misuse and mental health problems, as argued in a number of submissions to the Inquiry:

Efforts to reduce child abuse need to acknowledge and reflect the pervasiveness of family violence in our community. Violence within families underpins many social ills, injustices and harms that occur in Australian communities; it can be considered a 'rock in the pond' issue that ripples out and is prevalent in all human service systems (Domestic Violence Victoria submission, p. 2).

... we know from the research that [the issues affecting families and adolescents coming into care] are mental health, drug and alcohol and family violence. They are the three key presenting factors to family services, as they are for out-of-home care and child protection, so those three issues are very significant, but added to that is intergenerational stuff and very profound problems of attachment (Ms Butler, Ballarat Public Sitting).

There are a number of plans across the Commonwealth and state governments that address family violence, mental health and drugs and alcohol at a population level. These policies promote the use of primary prevention strategies, such as social marketing campaigns and school-based programs. These actions are consistent with the Inquiry's objective of seeking to reduce key risk factors.

Family violence

The *National Plan to Reduce Violence against Women and their Children 2010-2022* has been endorsed by the Council of Australian Governments (COAG) and sets out a framework for action over the next 12 years to reduce the levels of violence against women and children.

As highlighted in Chapter 2, a child witnessing family violence is child abuse and therefore this strategy to reduce family violence is considered a preventative measure for child abuse and neglect. It has a significant focus on primary prevention, with suggestions for strategies such as social marketing and school-based programs (COAG 2009d, p. 14).

Mental health

In relation to the risk factors associated with child abuse and neglect, parental mental health is a key issue. Supporting parents with a mental illness is both an important prevention and intervention strategy. The specific programs that seek to identify and respond to specific parental mental health issues are considered in more detail in Chapter 8.

Mental health promotion includes any action taken to maximise mental health and wellbeing among populations and individuals by addressing potentially modifiable determinants of mental health.

This includes:

- Influencing the social and economic factors that determine mental health, such as income, social status, education, employment, working conditions, access to appropriate health services and the physical environment; and
- Strengthening the understanding and the skills of individuals in ways that support their efforts to achieve and maintain mental health.

Mental health promotion aims to minimise the risk factors and increase the protective factors that influence mental health and wellbeing (Department of Health 2011a).

The *Because mental health matters: Victorian Mental Health Reform Strategy 2009-2019* identified promoting mental health and wellbeing as a distinct priority reform. Reform area 1 of the strategy identifies the goals for promoting mental health and wellbeing and preventing mental health problems by addressing risk and protective factors. The four goals are to:

1. Lead an organised and collaborative effort to promote positive mental health in targeted community settings;
2. Promote a socially inclusive society to strengthen recognised protective factors for mental wellbeing;
3. Renew Victoria's suicide prevention focus through a wide range of government programs; and
4. Reduce the risk factors for mental health problems associated with substance misuse (Department of Health 2009).

Alcohol

The Australian National Council on Drugs (ANCD) was established in 1998 as the principal advisory body to the Australian Government on drug and alcohol policy. It plays a critical role in ensuring the views of the many sectors involved in addressing drug and alcohol problems, as well as the community, are heard. An important component of the ANCD's work is to also ensure that policies, strategies and directions in the drug and alcohol field are consistent with the *National Drug Strategy 2010-2015*.

The *National Drug Strategy 2010-2015* includes an action to implement and support well-planned social marketing campaigns that address the risks of alcohol and promote healthy lifestyles and safer drinking cultures, including targeted approaches and local complementary initiatives for different population groups (Ministerial Council on Drug Strategy 2011, p. 10). Such targeted social marketing campaigns are promising for the preventative influence on a key risk factor for child abuse and neglect.

However, when a parent is intoxicated, their ability to provide adequate care and protection of young children is compromised (Dawe et al. 2008, p. 1). Accordingly, it is disappointing that the *National Drug Strategy 2010-2015* does not specifically identify the impact of alcohol use on parental capacity in its stated priorities.

Finding 3

Parental alcohol misuse is a significant risk factor for child abuse and neglect. The Inquiry considers that further investigation of the potential preventative benefits of public education and mechanisms such as minimum pricing of alcohol and volumetric taxing has merit.

The Victorian Government is in the process of developing a whole-of-government Alcohol and Drug Strategy. This could be an effective vehicle to address the negative impact of alcohol on parental capacity.

Recommendation 5

In preparing the whole-of-government Victorian Alcohol and Drug Strategy, the Department of Health should consider the impact of alcohol and drug abuse on the safety and wellbeing of children in families where parents misuse substances.

7.2.2 The universal service system

Universal services that have a role to play in reducing risk factors and strengthening protective factors for abuse and neglect include maternal and child health (MCH), child care, kindergarten, schools and primary health care.

The Inquiry notes that there is a lack of definitive research and evidence linking universal services to the reduction of abuse and neglect. While it is acknowledged that MCH nurses have a role to play in enhancing breastfeeding rates and securing parent-child attachment, and schools have a role to play in delivering safety awareness education to children, these organisations have goals and priorities that are much more expansive than the prevention of child abuse and neglect.

In the absence of evidence linking universal services to reducing child abuse and neglect, the Inquiry makes the assumption that increasing participation in universal services such as MCH, kindergarten and schools, will have an overall impact on reducing abuse and neglect. This is because of the increased access to and support provided by frontline health and education professionals, and the potential of services such as MCH, kindergartens and schools to bring families together and reduce social isolation. Moreover, universal services increase the 'visibility' of vulnerable children and families to the broader community, which in turn have an opportunity to respond to the needs of these children and families.

Efforts to prevent child abuse and neglect are most likely to be effective when a coordinated range of mutually reinforcing strategies is employed. The Inquiry suggests that further progress to prevent child abuse and neglect needs to be focused on communities with a high concentration of vulnerable children and families, and through the universal service platform, including MCH, early childhood education and care and broader educational settings.

Recommendation 6

The Department of Education and Early Childhood Development should implement strategies designed to encourage greater participation by the families of vulnerable children in universal services.

7.3 Opportunities to expand prevention efforts

Victoria has a good infrastructure of services with the potential to help prevent child abuse and neglect (see Appendix 7). From the MCH service, to early learning environments (including child care and kindergarten), to primary and secondary school, there are substantial opportunities available for child wellbeing to be enhanced and child abuse and neglect to be prevented.

7.3.1 Early years services

Victorian maternal and child health

Victoria has invested heavily, over many decades, in an effective and universally accessible MCH service. It is widely considered a cornerstone of the preventative effort that is required to support all Victorian children and families. MCH services provide a wide range of activities for all children aged 0 to 4 and their families, including intervention and referral, promotion and education, and support for families.

Maternal and child health nurses ... provide care to families around the core risk factors of child abuse such as social isolation, such as lack of parenting skills, maternal and ill health, postnatal depression, sleep deprivation, breastfeeding difficulties, post-traumatic birth, all of these are the known risk factors that may contribute to child abuse and neglect ... (Ms Clark, Broadmeadows Public Sitting).

The MCH service is built around 10 key visits with an MCH nurse. According to the *Competency Standards for the Maternal and Child Health Nurse in Victoria* (Victorian Association of Maternal & Child Health Nurses 2010) MCH nurses are required to assess and monitor the health, growth and development of children from birth to school age through:

- Collecting a comprehensive medical, obstetric and family history;
- Identifying protective and risk factors in the child's environment;
- Identifying a child at risk of or experiencing neglect and abuse and acting on professional observation and judgment; and
- Responding to a child at risk of or experiencing abuse, and making reports in accordance with the *Children Youth and Families Act 2005*.

MCH nurses also undertake physical and developmental assessment of the child, promote breastfeeding, appropriate nutrition, and maternal physical and emotional health and wellbeing.

MCH nurses also play a key role in facilitating community linkages and support, including through establishing new parent groups, to reduce social isolation and improve social connectedness. They promote effective and safe parenting styles and assist parents to understand the needs of their infant or child in relation to their child's stage of development. They also promote the importance of the family in the health and development of the child.

The most recent independent evaluation of MCH (KPMG 2006) found numerous successes associated with this service including client satisfaction (in excess of 95 per cent), progressive introduction of system innovations and planning processes that integrate MCH within municipal and other local service systems. The evaluation concluded that MCH is achieving its objectives for most Victorian parents and children (KPMG 2006, p. 2). However, as noted recently by the Victorian Auditor-General's Office (2011b), participation in MCH, particularly after the age of 12 months, is an issue, with declining proportions of families not participating in the service, as shown in Table 7.1.

Table 7.1 Participation in maternal and child health checks, Victoria, 2005-06 to 2009-10

Visit	2005-06 participation levels, per cent	2009-10 participation levels, per cent
Home consultation	96.0	99.8
2 weeks	93.1	96.9
4 weeks	91.3	95.4
8 weeks	91.7	94.7
4 months	89.4	91.5
8 months	82.4	82.7
12 months	78.3	80.3
18 months	68.0	71.6
2 years	64.7	69.1
3.5 years	58.0	63.1

Source: DEECD 2007a, DEECD 2011c

The Victorian Auditor-General noted that by 18 months, almost 30 per cent of all children and families no longer participate in the service. The report concludes that the Department of Education and Early Childhood Development (DEECD) needs to better understand the reasons for the drop off in the universal service after the eight-week check. (A summary of the Auditor-General's findings in relation to early childhood development services are shown in the box).

Early childhood education and care

The Commonwealth Government is a partner with the Victorian Government in providing comprehensive and quality early childhood education and care, having a critical role in early childhood support through care and family payments. The reforms that have been pursued through COAG in recent years are critical to the progressive development of these services, in particular through:

- Development of a national early childhood development strategy called *Investing in the Early Years*;
- The *Closing the Gap: National Partnership Agreement for Indigenous Early Childhood Development* to 'close the gap' in Indigenous early childhood development outcomes and improve participation;
- The *National Partnership Agreement on Early Childhood Education* to provide universal access by 2013 to a high-quality kindergarten program for 15 hours a week, 40 weeks a year in the year before school; and
- The *National Early Years Learning Framework* for all educators who work with children from birth to five years.

A number of long-term studies have demonstrated that high quality early childhood education and care can help to prevent or mitigate the problems that emerge for children being raised in disadvantaged families (Centre for Community Child Health 2007). The long-term savings for society are also widely argued, including by United Nations Children's Fund (UNICEF), which states there is no convincing reason in contemporary society for spending less on early childhood education and care than on the educational needs of older children (Adamson 2009, p. 31).

The engagement of vulnerable children in universal early childhood services is widely acknowledged as one of the biggest challenges facing policy makers and service providers (McDonald 2010, p. 1). This challenge is not limited to the Victorian or Australian context, as UNICEF notes that the lack of statistics regarding early childhood education for disadvantaged and vulnerable children makes it more difficult to craft effective policy responses (Adamson 2009, p. 23).

The 2006 Organisation for Economic Co-operation and Development (OECD) *Starting Strong* review of early childhood services found: '...that direct public funding of services brings more effective governmental steering of early childhood services, advantages of scale, better national quality, more effective training for educators and a higher degree of equity in access' (Adamson 2009, p. 20).

The report states that, in 2003, Australia was spending just 0.4 per cent of gross domestic product on early childhood services, well below the OECD average of 0.7 per cent. The countries at the top of the expenditure table (Iceland at 1.8 per cent, Denmark at 1.7 per cent, Finland at 1.3 per cent, Sweden at 1.3 per cent and France at 1.2 per cent) spend approximately double the OECD average. These same OECD countries meet eight or more of the OECD early childhood benchmarks (Adamson 2009, p. 27).

What this OECD data doesn't show well is that Australia is unique in that a large proportion of spending on early childhood education and care occurs in the private sector, meaning that access to most early childhood educational settings is restricted by cost. The Commonwealth Government contributes towards the cost of child care through two funding mechanisms: the Child Care Benefit and the Child Care Rebate.

The Child Care Benefit is available for families that access a family tax benefit and place their child in approved care for up to 24 hours per week. The Child Care Rebate is available only to families that pass a test designed to encourage workforce participation. The subsidy approach to child care means that, for many families, cost remains a barrier to accessing child care.

Appendix 7 provides the number and the proportion of Victoria's children who are attending child care, principally long day care and family day care. The Inquiry sought to also include material regarding the levels of Victorian children's non-participation in early childhood education and care, particularly for children aged one to three years. Unfortunately this is not information that is collected by DEECD.

In Victoria attempts to overcome this exclusion are being trialled through the new pilot program Access to Early Learning. The primary focus of the Access to Early Learning initiative is the engagement of vulnerable children in three year old early childhood education and care programs. This program is discussed in more detail in Chapter 8.

Although acknowledging that Victoria's current 95 per cent kindergarten participation rate meets the nationally agreed target for universal access, the Victorian Auditor-General argues for further improvements to meet the needs of the most vulnerable (refer to box). The UNICEF report card on early childhood services suggests that governments need to plan, deliver and monitor early childhood services in a way that is able to guarantee the inclusion of the most disadvantaged and vulnerable (Adamson 2009). This may mean greater government subsidisation, flexible budgets, regional or location-based solutions, more training and skills development in the places of greatest need.

Early years services

This analysis of MCH and early childhood education and care not only shows the value of these early years services to children, but they also show the lack of universal service offerings to children and their families between the ages of one and three. MCH services include only three visits with a MCH nurse after the age of one, 18 months, two years and 3.5 years.

Most reports to child protection occur within the first year of a child's life. As shown in Figure 2.3 in Chapter 2, the number of reports to child protection that originate when a child is aged 1 to 3 are around 3,000 per age group, per year. This is a significant number and begs the question: Can more be done to prevent this high number of children being referred to the tertiary end of the service spectrum?

As an existing and strong service platform, MCH has enormous potential to promote health, development and wellbeing for the 0 to 3 age group; however, it is noted by the Inquiry that participation levels among this age group in the last three visits are less than 70 per cent. The reasons why approximately 30 per cent of families are not participating are multifaceted and complex, relating to issues such as location of centres, appointment times, costs of travel and parental work commitments. In this context, it may not be appropriate for the traditional service method to continue for the later MCH visits. Strategies such as linking later MCH checks to immunisation clinics, playgroups, child care, family day-out activities, local libraries and shopping centres could be explored as ways of 'reaching out' to families.

That these services are not currently accessed by all Victorian children who are eligible for the service is a problem in need of priority attention.

Playgroups

The Inquiry has heard evidence of Victoria's long history of formal and informal playgroups. Playgroup Victoria is a statewide organisation established in 1974 to achieve outcomes for all Victorian children, parents, families and communities through the platform of a playgroup.

Playgroups are a cost effective, flexible and responsive model that can be replicated without the need for extensive infrastructure in the heart of any community, including Indigenous and CALD communities. Playgroups play a vital role in responding to the needs of children and families at risk of child abuse and neglect and build more connected and resilient communities (Playgroup Victoria submission, p. 3).

Victorian Auditor-General's report into early childhood development services: access and quality

Summary of relevant findings and recommendations

Key findings

- Access to universal MCH and kindergarten services and services for vulnerable children has improved over the five years to 2010.
- Despite the increase in MCH participation rates, attendance at the 10 health and developmental checks progressively declines after the first check.
- This pattern of progressive decline in the take-up of health and developmental checks has not improved and remains consistent with 2005-06.
- These checks play an important role in the early detection and treatment of health and developmental problems. Checks must be timely as any delay in detection increases the likelihood that children remain vulnerable and at risk, resulting in a greater cost to the community and government.
- While the current 95 per cent kindergarten participation rate meets the nationally agreed target for universal access, DEECD has not established who the non-participants are and, most importantly, whether they include the children and families most in need of the service.
- Local governments collect information and data on children and families that could better inform DEECD's understanding of demand (DEECD does not use it).
- While DEECD has information on the number of vulnerable children and families that use the targeted services, variable service referral processes, inconsistent data collection methods, unreliable data on population projections, and the department's narrow definition of vulnerability means that DEECD is not in a position to know whether the information it has accurately reflects real demand.

- The narrow definition of vulnerability used by DEECD means that it is not in a position to know whether the information it has accurately reflects real demand.
- Consequently, DEECD does not know whether it is reaching all vulnerable children and families, and it does not know the reasons why or extent to which children and families experience problems accessing early childhood services.
- DEECD does not sufficiently understand or effectively manage demand for early childhood services. It needs to better identify which children and families do not use its services, and why, and then act to remove barriers to participation.
- As local governments also have statutory responsibility to plan and provide services for the local community, which include MCH and kindergarten services, there is a risk that ambiguity of roles can result in a lack of clear accountability for performance. DEECD has not actively managed this risk and needs to take a stronger leadership role in this regard.

Recommendations

- That DEECD develop a better understanding of service demand, particularly for the vulnerable and disadvantaged by:
- Reviewing its definition of vulnerability to guard against children and families 'slipping through the net';
- Working in partnership with service providers to identify and act to remove barriers to access and participation, especially for the vulnerable and disadvantaged; and
- Working in partnership with service providers to identify and act to mitigate the reasons for the fall in attendance at MCH checks after the first visit (VAGO 2011b, pp. viii-xi).

It is noted that the form of playgroups can vary, from a community-based format, to supported/facilitated formats and intensive formats. The latter two formats will be discussed in more detail in Chapter 8, given their focus on targeting vulnerable children and families. Community playgroups are considered universal in their reach, as they are available to anyone who wishes to access them. They tend to be organised and led by parents at a local neighbourhood level. Playgroup Victoria has estimated that it supports more than 17,000 families that attend these playgroups across the state.

Playgroups are for babies, toddlers and preschoolers, and their parents or carers. They offer a cost-effective and universal platform for child and family support, and provide parents and carers with the chance to meet other people going through similar experiences, which can ease the isolation that can come with caring for young children. Families can be introduced to community, health and support services while they are at playgroup.

An international evaluation of playgroups found they can be the first service that a family engages (however, in Victoria, the existence of MCH services means that it is not the case). For many parents, participation in their local community playgroup represents a first step towards further training and education, and the beginning of their community involvement. Playgroups provide ready access to a listening ear, advice and support, as well as information on accessing other supports and agencies (French 2005, p. 61).

The Telethon Institute for Child Health conducted research on the association between playgroup participation, learning competence and social-emotional wellbeing for children aged 4 to 5 years in Australia, and found that boys and girls from disadvantaged families scored 3 to 4 per cent higher on learning competence at age 4 to 5 if they attended a playgroup at age 0 to 1 and 2 to 3 years, when compared with children from disadvantaged families who did not attend a playgroup (Hancock et al. in press, p. 2). Demographic characteristics analysed in the research also showed that disadvantaged families were the families least likely to access playgroups.

The *Take a Break* child care program lapsed at the end of the 2010-11 financial year, following a review that suggested it was inefficient and poorly targeted. With a state government investment of more than \$800,000 per annum, the Inquiry considers that action be taken to fill the void for families left without access to affordable support. The Inquiry recommends that DEECD invest funding into community playgroups in communities where there are high numbers of vulnerable children and families.

Recommendation 7

The Government, through the Department of Education and Early Childhood Development, should:

- Examine the capacity of local governments in low socioeconomic status areas to provide appropriate Maternal and Child Health and Enhanced Maternal and Child Health services, consistent with the concentration of vulnerable children and families, particularly as the current funding formula for Maternal and Child Health is based on a 50 per cent contribution by local government; and
- Increase investment and appropriate infrastructure in universal services including maternal and child health, kindergarten and community playgroups, to communities that have the highest concentration of vulnerable children and families to increase the participation of vulnerable children in these services.

The increased investment in maternal and child health and enhanced maternal and child health should focus on:

- Enhanced support to families whose unborn babies are assessed as vulnerable to abuse or neglect, especially as a result of pre-birth reports; and
- A more intensive program of outreach to families of vulnerable children who do not attend maternal and child health checks, particularly in the first 12 months of life.

Recommendation 8

The Department of Health should develop and lead a consistent statewide approach for antenatal psychosocial assessment so that problems such as family violence, parental mental illness and substance misuse in pregnancy can be more effectively addressed.

7.3.2 School age children and adolescents

Schools have an important role to play in promoting general child wellbeing and reaching out to families in the local community. The universal and compulsory nature of school attendance, places a school in a unique position relative to a family. For many children, teachers are a significant figure in their lives, with enormous potential to impact on their wellbeing and life outcomes. For vulnerable children in particular, schools have a unique opportunity to identify signs of vulnerability early, as well as implement strategies to impact positively on these factors.

DEECD recognises that ‘protecting children from significant harm caused by abuse and/or neglect is a shared responsibility involving parents, child care providers, schools, communities, government organisations, police and community agencies’ (DEECD 2011b).

DEECD’s approach to the protection of all children and young people involves operational practice, educational and student services, and partnerships with families and communities. As shown in Appendix 7 the main program dedicated to assessing the wellbeing of primary school children is through the Primary School Nursing Program. This program offers a free health care and referral service to all Victorian children attending government, independent and Catholic primary schools, and English Language Centres. The universal health assessment relies on concerns expressed by parents or teachers to provide a more focused health consultation. Nurses will refer children and families for whom they have concern to other relevant health or social services, including general practitioners, Child FIRST agencies and statutory child protection.

In addition to its role in overseeing the capability of the broader teaching and early childhood education workforce, DEECD has a range of further programs designed to facilitate partnerships with families and communities. For example, four extended school hubs are being piloted in Victoria under the Smarter Schools National Partnerships. The goal of the hubs is to strengthen partnerships between schools, community and business to support students to achieve their education potential by:

- Reducing barriers to learning; and
- Connecting and coordinating external activities delivered before, during and after school hours to provide complementary learning for students and families.

DEECD also has a range of further programs designed to keep vulnerable children/youth engaged in the school environment. For example, as part of the East Gippsland Youth Mentoring Project young people at risk of leaving school early are matched with a volunteer mentor for one hour per week for one term to one year. The mentoring program has been operating for six years and has a proven track record of success at keeping young people engaged with school. In 2010, 53 of the 54 young people who had a mentor stayed at school.

Government secondary colleges employ student welfare coordinators who are responsible for helping students with issues stretching from truancy to parent-adolescent conflicts to depression. This reflects that needs of children between primary and secondary school settings are distinctly different, and the challenges of adolescence necessarily need to be taken into account when determining what an appropriate service response would look like. Many of the programs in secondary schools are designed to address risk factors for child wellbeing and are aimed at those identified as vulnerable. They are described in Chapter 8 which examines early intervention.

The opportunities for schools to impact upon the prevention of child abuse and neglect are multifaceted. From the delivery of personal safety and sex education programs, to building strong family school relationships and operating as centres for the broader community, they have enormous value. As described in brief above, DEECD has a number of programs that operate at a local level to increase the connections between schools and vulnerable children, their families and the community. The challenge is to harness the knowledge and evidence gained through their local level programs and, wherever possible, apply it to other similar schools and environments.

Additionally, the Commonwealth funded ‘headspace’ and National Mental Health Foundation suicide prevention initiatives operate in schools, creating a vehicle for reaching secondary school students with mental health and related problems. Chapter 8 considers school-based programs in further detail.

7.3.3 Support and information for parents, carers and families

Valuing parenting

As noted in Chapter 6, the preamble to the United Nations *Convention on the Rights of the Child* establishes the family as 'the fundamental group of society and the natural environment for the growth and development of all its members and particularly children'. The Inquiry received several submissions suggesting that there should be a much greater focus on primary prevention activities by enhancing the quality and nature of parenting support provided through universal services, especially in early education and care:

The family is the key site of intervention for child protection. Vulnerable children are a product of vulnerable families, and multiple interventions may be required which support the whole of family as well as individual members (Drummond Street Services submission, p. 3).

Support the development and expansion of practical parenting information, with a view to increasing accessibility of information to higher risk groups and integrating research informed information with service delivery. Build the capacity of universal education and care services to provide evidence based parenting interventions (Parenting Research Centre submission, p. 8).

Improving parental capacity to manage the behaviour of their children can reduce the risk of child physical abuse. A review of parent education programs undertaken by the National Child Protection Clearinghouse (Holzer et al. 2006) found there is a range of education programs operating internationally that have improved parenting competence, and that effectively address risk factors for child abuse and neglect, and in some instances, where direct measurements were made (for example, through child protection service data), resulted in fewer incidents of child abuse and neglect.

Parents face new challenges as children develop, from feeding and settling problems in infants, to children starting school, travelling to school by themselves, bullying, social networking, entering adolescence, to forming adult relationships. These challenges can be overwhelming, and for some parents to navigate through all of these alone, without dedicated information and support, may be difficult.

The Triple P – Positive Parenting Program was developed by Matthew Sanders and colleagues at the Parenting and Family Support Centre in the School of Psychology at The University of Queensland. It is a multi-level, evidence-based parenting and family support strategy designed to prevent behavioural, emotional and developmental problems in children and provide support for parents and families. It aims to help to develop a safe, nurturing environment and promote positive, caring relationships with children, and to develop effective, non-violent strategies for promoting children's development and dealing with common childhood behaviour problems and developmental issues. The emphasis is on positive parenting principles, promoting children's development and managing specific child behaviour concerns rather than on developing a broad range of child management skills (Sanders & Turner 2005).

In Victoria there are new parent groups available for parents and carers of infants through MCH services. The purpose of the groups is to:

- Enhance parental and emotional wellbeing;
- Enhance parent-child interaction;
- Provide opportunities for first-time parents to establish informal networks and social supports; and
- Increase parental confidence and independence in child rearing.

There is also a range of low-intensity information, education and parenting support services provided through universal platforms and managed by DEECD. These include:

- Services provided to parents and professionals by regional parenting services (nine services, one in each DEECD region) and the Council of Single Mothers and their Children;
- Parenting supports provided to parents of children with disabilities and the professionals who work with them through the Strengthening Parents Support Program (services located in each of the nine DEECD regions);
- Signposts – a tailored parenting program for parents of children with disabilities and/or learning difficulties; and
- Parentline – a telephone service for parents and carers of children aged 0 to 18 years and professionals that operates seven days a week/365 days per year between the hours of 8.00 am and midnight.

The Australian Government funded Raising Children Network website also offers a resource to support families in the day-to-day raising of children from birth to their teens, via the information and resources on the website. It is also a resource for relevant practitioners. The website arose from the Parenting Information Project in 2004, which found that parents wanted a single source of reliable and easily accessible information on parenting that was government-sponsored and therefore credible and trustworthy. The website was launched in 2006 and has received more than 17 million visits to date. Since its launch, the website has been expanded to include information for parents of teenagers (aged up to 15 years), information for parents of children with disabilities, and other interactive products and online forums. The website has the following objectives:

- Providing assistance in caring for children;
- Providing information on being a parent;
- Assisting professionals;
- Facilitating parents in the use of professional services;
- Facilitating community connectedness; and
- Facilitating community and professional partnerships (Department of Families, Housing, Community Services and Indigenous Affairs 2011).

Providing additional support to families is a key step in securing the future safety and wellbeing of Victoria's children. Targeted support is needed for families in need, such as families with a parent with mental illness. This is discussed further in Chapter 8.

Notwithstanding the importance of these services, the Inquiry's analysis suggests there is an opportunity and need to increase the universally available/accessible parenting supports available in Victoria. Such supports should be built on existing evidence (such as Triple P) of what works, and provide support to parents appropriate to their child's life stage. These supports should leverage off the capacity and expertise already contained within universal service platforms including MCH, kindergarten, primary and secondary schools, major employers and training providers.

Recommendation 9

The Department of Education and Early Childhood Development, in partnership with the Department of Human Services, should develop a universal, evidence-based parenting information and support program to be delivered in communities with high concentrations of vulnerable children and families, at key ages and stages across the 0 to 17 age bracket.

Preventing child sexual abuse

The risk of child sexual abuse is a critical issue requiring reconceptualisation and further action. The Inquiry received several submissions calling for an increased focus on the prevention of child sexual abuse, as demonstrated by this verbal submission to the Inquiry:

I had no knowledge, skills or resources to help me protect children against a paedophile. Nobody had ever given me any clue about the indicators of a paedophile. Nobody had ever told me that it would most likely be a close friend that would be my children's abuser. Nobody taught me how to talk to my young children about their bodies and sex in a way that was appropriate for their young age or how to talk to them about appropriate adult behaviour (Ms L, Bendigo Public Sitting).

Research conducted by Smallbone and Wortley (2001) provides five key findings about child sexual abuse. These are:

1. Child sexual abuse overwhelmingly involves perpetrators who are related to or known to the victim;
2. It is more common for offenders to employ strategies to gain the compliance of children, such as giving gifts and lavishing attention, rather than physical coercion;
3. Serial child sexual offending is relatively uncommon;
4. Perpetrators of child sexual abuse are three times more likely to abuse female than male children; and
5. Child sexual abuse offenders do not necessarily form a distinct offender category, with many having previous non-sexual offences (Smallbone & Wortley 2001, p. 5).

These findings are particularly helpful in challenging child sexual abuse myths, such as the prevalence of 'stranger danger', and for effective focusing of future prevention strategies.

Research into the primary prevention of child sexual abuse suggests there are two distinct points of focus: first to prevent children from being sexually abused for the first time; and second to prevent potential offenders from committing a first child sexual abuse (Smallbone et al. 2008, p. 48). The research authors consider approaches directed to the offender, the victim, the situation and the community.

Offender-focused approaches

Current approaches to preventing potential offenders from first sexually abusing a child rely heavily on formal deterrence strategies. These strategies rely on the assumption that public dissemination of successful prosecution outcomes for known offenders will dissuade would-be offenders from first committing such an offence themselves. Smallbone et al. conclude that while the ongoing existence of relevant laws and penalties are important for the preclusion of increasing child sexual abuse, it is doubtful that continuing to increase formal penalties for sexual offences will contribute anything further to primary prevention (Smallbone et al. 2008, p. 198).

An alternative strategy is described as 'developmental prevention' to forestall some of the developmental deficits that may lead a person to become a sexual abuser – such as early attachment failures in childhood, poor school adjustment, and the non-involvement in early parenting as an adult (Finkelhor 2009, p. 184). The contention in practical terms is that increasing investment in universal developmental crime prevention programs would yield positive benefits for preventing sexual abuse and, at a broader level, whole-of-government policy can contribute by striving to create the economic and social conditions necessary for families and communities to provide optimal care and support for children (Smallbone et al. 2008, p. 200).

Victim-focused approaches

This approach has focused on education, with the central goal of imparting skills to help children identify dangerous situations and prevent abuse, as well as to teach them how to refuse approaches, how to break off interactions and how to summon help (Finkelhor 2009, p. 179). Smallbone et al. (2008) found little convincing evidence for the effectiveness of these programs for preventing sexual abuse. They suggest that if these programs are to remain part of a broader prevention strategy, revisions are needed to better align their aims and content with knowledge concerning child sexual abuse offender modus operandi. They suggest a shift from the traditional 'resistance training model', where children are taught to 'resist' potential child sexual abuse offenders, to a 'resilience training' model, where attempts are made to reduce general psychological and emotional vulnerabilities, such as low self-esteem and excessive neediness (Smallbone et al. 2008, p. 201).

Situation-focused approaches

Parents and carers employ many commonsense precautions to reduce children's exposure to a range of hazards, including the risk of sexual abuse. Similarly, institutional child care may take precautions against sexual abuse. However, it is likely that these precautions may be based on misconceptions (for example, that the greatest risk is from strangers; that offenders are likely to look 'sleazy'; or that criminal history checks on prospective employees will make child-related organisations safe) (Smallbone et al. 2008, p. 202).

Smallbone et al. suggests that situational prevention in home settings may be supported by universal education strategies designed to better inform the public about specific risk and protective factors. However, he contends that it is at an institutional level that situational techniques are most conducive, recommending the requirement of systematic assessment of risks and the development of risk management plans within child-related organisations (Smallbone et al. 2008, p. 202).

Community-focused approaches

Universal awareness and education strategies are the mainstay of current community-focused approaches to primary prevention (Smallbone et al. 2008, p. 202). An alternative approach is universal community capacity building, such as universal parenthood education, neighbourhood family support services and home visiting programs (Smallbone et al. 2008, p. 204).

Awareness raising campaigns such as White Balloon Day, founded during Child Protection Week in 1997, have succeeded in giving the problem of child sexual abuse a public profile, and the support that is offered through its umbrella organisation Bravehearts is an important service for those requiring help. Bravehearts is an advocacy and support organisation comprising survivors, parents, friends, partners, professionals and non-abusive members of the community who share in the belief that child sexual assault must stop (Bravehearts 2010).

Similarly, the Love Bites program, developed by the National Association for Prevention of Child Abuse and Neglect (NAPCAN) in 2008 and run in schools to educate young people about respectful relationships and reducing the incidence of relationship violence in the community, plays an important role in both preventing and addressing child sexual abuse.

The *National Framework for Protecting Australia's Children 2009-2020* states that the prevention of child sexual abuse requires a different response to that of neglect, emotional and physical abuse. It states that:

- The vast majority of child sexual abuse perpetrators are family members or someone well known to the child or young person;
- Risk factors for child sexual abuse are exposure to family violence, other types of abuse and neglect, pornography, highly sexualised environments and inadequate supervision;
- Raising awareness and knowledge with children and in the broader community about risks can foster protective behaviours and may help to increase detection of abuse;
- The importance of educating young people about healthy relationships is increasingly being recognised;
- Raising awareness about the role of the internet as a mechanism for the sexual abuse or exploitation of children and young people is important; and
- Organisations, businesses and institutions can also play an important role in protecting children through the development of policies and procedures to create child-safe organisations (COAG 2009e).

In Victoria schools do not deliver educational warnings about sexual abuse in schools as part of the formal curriculum. The sexuality education curriculum (compulsory from Year 3) includes a focus on protective behaviours and personal safety. In secondary schools, there is a focus on supporting respectful relationships and teachers cover topics such as: respect and relationships; gender identity; sexual intimacy; understanding sexual harassment; consent and the law; and developing respectful practices. Child Wise is also contracted by DEECD to provide the Wise Child Personal Safety Training Program to all school staff across primary, secondary and special school settings, with the aim that they are able to deliver a whole-of-school approach to personal safety. Child Wise is an international child protection charity committed to the prevention and reduction of sexual abuse and exploitation of children (Child Wise 2011).

The Inquiry believes more can be done to prevent child sexual abuse, particularly through the provision of information and education to parents and caregivers of children. Research undertaken by Babatsikos found that, while many parents wanted to talk to their children about the prevention of child sexual abuse, many felt they did not have the skills or language to do so. This study suggested that prevention programs, best delivered through educational environments, could focus on providing parents with language and experience that would increase their confidence and skills in discussing such sensitive issues with their children (Babatsikos 2010, p. 124). The range of existing expertise and resources already available through organisations like Child Wise and Bravehearts would enable this action to be implemented without delay.

Recommendation 10

The Department of Education and Early Childhood Development should develop a wide-ranging education and information campaign for parents and caregivers of all school-aged children on the prevention of child sexual abuse.

7.3.4 The importance of the community environment

The ecological model of child development described in Chapter 2 includes reference to the community environment of a child, including their relationship to networks and formal services. A person's connection with their broader family, work, interests and local community has been identified by the Australian Government as one of five key domains of opportunity that assist people to be socially included (Australian Social Inclusion Board 2008). Promoting connectedness with the broader community environment is important because children and families that are socially excluded have less support, lack positive role models, and feel less pressure to conform to social norms relating to parenting, are at greater risk of abuse and neglect.

The state government, together with local governments, has a major role in promoting community connectedness and social inclusion, principally through their planning and transport responsibilities. These responsibilities include the need to plan local communities well for public transport, access to services, shared spaces and precincts that can act as a community hub. Infrastructure such as parks, public libraries, galleries, museums and sporting facilities allow families to access low-cost or free activities, social infrastructure (MCH centres, playgroups etc), schools and education, as well as get involved with their community.

For vulnerable or isolated families, this can assist in providing emotional support or positive role models that they may be lacking.

Programs such as Neighbourhood Renewal give promise to what can be done to support vulnerable families in vulnerable communities. These programs enable families to be connected to, and supported by, their local community through community building activities and local employment initiatives (St Luke's Anglicare submission, p. 8-9).

The communities that make up Victoria differ in many ways. From metropolitan to regional, from high-density living to farmlands, from communities with large numbers of recently arrived immigrants, to the communities of our first Australians. The needs of each community will be different, and the supports that they offer each other will also differ. When considering ways that communities can support vulnerable children and families, these local differences need to be taken into account.

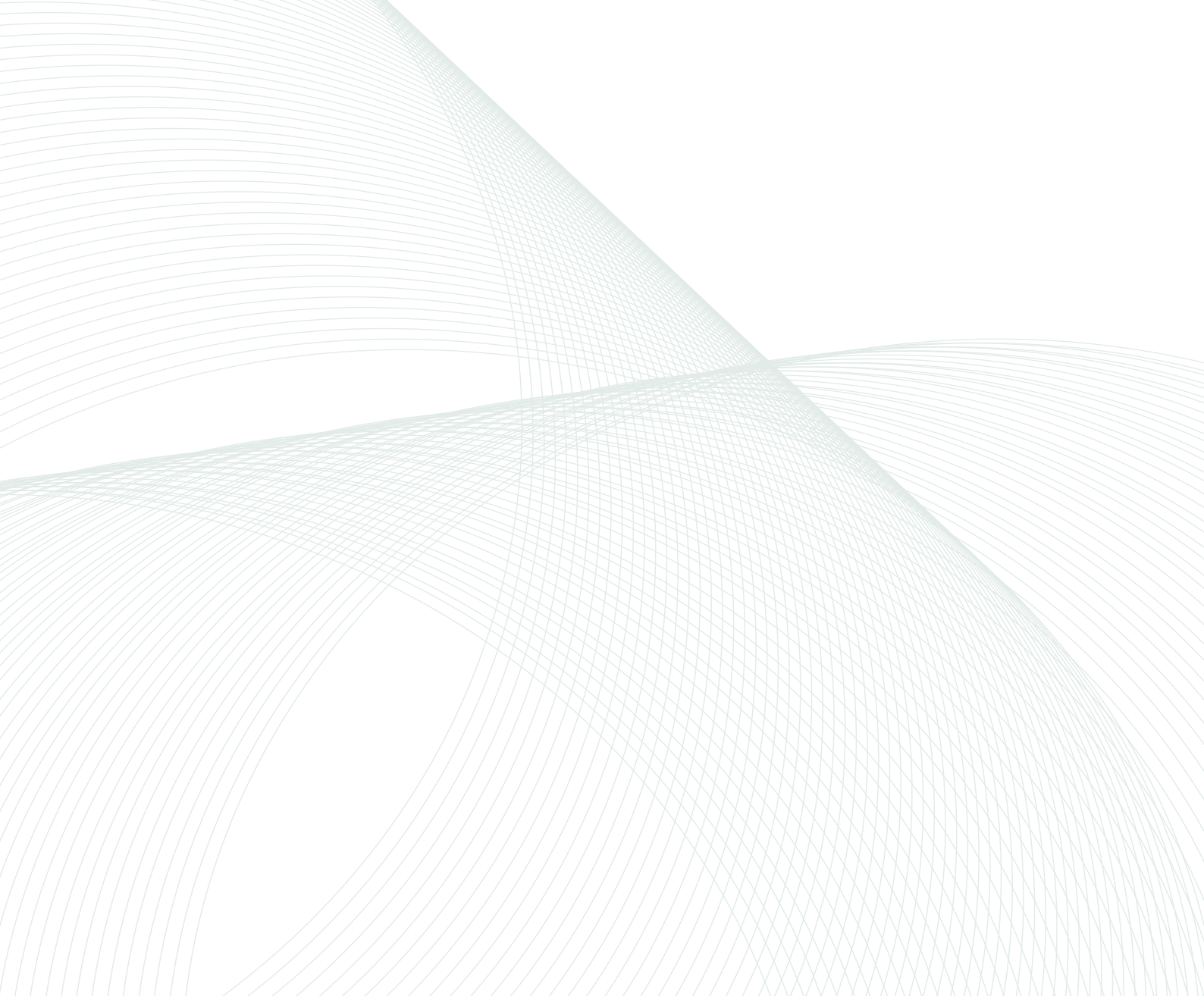
The Department of Planning and Community Development (DPCD) supports a range of programs and initiatives that respond to disadvantage and the needs of vulnerable children and families in communities. Approximately \$150 million will be distributed over four years (2011-2015) through programs such as community support grants, advancing country towns and the regional growth fund to strengthen communities.

Matter for attention 2

The Inquiry draws attention to the community building activities of the Department of Planning and Community Development and considers they represent a significant opportunity to directly link with and support efforts to reduce the incidence and impact of child abuse and neglect on an area basis.

7.4 Conclusion

Victoria has a strong infrastructure of universal services for infants, children and young people, including through MCH services, playgroups, kindergarten and schools. There are a number of opportunities to strengthen Victoria's prevention approach, in particular, by identifying and providing early support to vulnerable children and families, focusing on communities that have the highest concentration of vulnerable children and families, increasing parenting education programs and providing increased education and information about how to prevent child abuse and neglect.



Part 4: Major protective system elements

Chapter 8:

Early intervention

Chapter 8: Early intervention

Key points

- Evidence from overseas shows that early intervention programs – when well designed and resourced – can be an effective method of improving outcomes for vulnerable children and young people, including reducing the risk of child abuse and neglect. Studies have also shown early intervention can be a more cost-effective investment in the long term than later interventions.
- Victoria has a substantial range of early intervention programs with the potential to support vulnerable children, young people and their families. These include early childhood programs, school supports, health services, community-based family services and specialist adult services. However, these programs do not combine to form a comprehensive, coherent and coordinated system of early interventions that address the diverse needs of vulnerable children and their families.
- Supporting vulnerable children and young people should be part of the core business of services in each of these sectors. While there are a number of promising practices, they are varied, not coordinated and not consistently adopted. The Inquiry recommends additional investment to support services to identify and respond to risk factors for child abuse and neglect.
- Existing data systems and practices within services do not allow Victoria to identify all vulnerable children and young people who could benefit from early intervention services.
- Child FIRST and the local Alliances of family services provide a basis for developing an accessible entry point to an integrated network of services to meet the full range of needs of vulnerable children and their families. However, the capacity of Alliances to deliver services that meet local needs is being undermined in several catchments because of a lack of suitable providers and because Alliances are not undertaking effective service planning.
- The Inquiry recommends that consistent governance arrangements be established across catchments to strengthen Alliances' accountability for their performance. Accountability arrangements should be strengthened further by ensuring the Department of Human Services' funding agreements with Alliance lead agencies clearly specify the community service organisation's role and responsibilities, and include appropriate accountability and performance measures.
- There is an opportunity to expand upon the existing Alliances of family services and statutory child protection services to develop broader, more coherent Child and Family Service Networks encompassing specialist adult services, health services and targeted programs linked to universal services. This would support the provision of an integrated package of services that meets the full range of needs of vulnerable children and their families.
- The Inquiry recommends that the legislation governing relevant services should establish the accountabilities and responsibilities of services to act in the best interests of children and young people, and to prioritise service delivery to vulnerable children, young people and their families.
- Specialist adult services and health services should be supported to develop child-and family-sensitive practices that address the needs of vulnerable children and their families.

8.1 Introduction

This chapter is concerned with the role of early intervention in protecting vulnerable children and young people from the risk of abuse and neglect. The Inquiry has been asked to develop recommendations to enhance early identification of, and intervention targeted at, children and families at risk including the role of adult, universal and primary services, and ways to strengthen the capability of those organisations involved.

This chapter begins by considering what early intervention is and the evidence of its effectiveness. A snapshot of the range of early intervention services in Victoria is then provided across early years programs, school programs, community-based family services, general health services and specialist adult services. An analysis of the performance of the current service arrangements follows. The chapter concludes with recommendations to strengthen early intervention for vulnerable children in Victoria.

8.1.1 What is early intervention?

Many participants discussed prevention and early intervention in the consultation phase of the Inquiry, with the terms often being used interchangeably. For the purposes of this Report, the Inquiry has adopted the following definition:

Inquiry definition of early intervention

Interventions directed to individuals, families or communities displaying the early signs, symptoms or predispositions that may lead to child abuse or neglect.

This means that early intervention occurs when heightened vulnerability for a child or young person has been identified. Effective early intervention requires both the identification of vulnerable children and young people, and a service response that meets the needs of the child or young person and their family.

Early intervention services are targeted interventions based on the identification of broad risk factors. As described in Chapter 7, from a public health perspective, secondary prevention or early intervention services can be considered to lie between:

- Primary prevention services, often universal in nature, that target whole communities in order to reduce risk factors and strengthen protective factors that contribute to abuse and neglect; and
- Tertiary services that focus on children and families where there is a significant risk of harm, or where abuse has already occurred.

In Australia and other developed countries, government support for vulnerable children has historically focused on tertiary interventions after abuse or neglect has occurred. In recent years, however, governments have been increasingly seeking to intervene early to support vulnerable children and families.

This is most clearly demonstrated in Australia by the Council of Australian Governments' (COAG) *National Framework for Protecting Children 2009-2020*. Through the framework, the Commonwealth, state and territory governments committed to early intervention as one of six 'supporting outcomes' or goals for protecting children:

All children and families receive appropriate support and services to create the conditions for safety and care. When required, early intervention and specialist services are available to meet additional needs of vulnerable families, to ensure children's safety and wellbeing (COAG 2009e, p. 17).

The framework noted that state and territory governments were already 'implementing reforms to their statutory child protection systems – all focused on early intervention' (COAG 2009e, p. 9).

Early intervention does not necessarily involve intervention early in the life of a child. Rather, early intervention services are those that are delivered early in the life of an identified problem or early in the causal pathway. While many of the programs and research focus on young children, the concept of early intervention is also applicable and relevant to older children and young people.

8.1.2 Effectiveness of early intervention

Governments' increasing focus on and investment in early intervention, especially in early childhood, has been prompted by research showing that early interventions are more cost-effective in the long term than later interventions aimed at treating the impact of problems such as abuse and neglect (Stronger Families Learning Exchange 2002). It is argued that it is more cost-effective to tackle problems earlier because it is easier to succeed; if they are tackled later they are likely to escalate and intensify. As a result, intervening later is usually more costly and often cannot achieve the results that early interventions are able to deliver (Allen 2011, p. xiv). Chapter 2 has shown that the estimated lifetime cost of child abuse and neglect that occurred for the first time in 2009-10 is between \$1.6 and \$1.9 billion.

Advances in neuroscience and the behavioural and social sciences have improved our understanding of how healthy development happens in children, how it can be derailed and what societies can do to keep it on track (Shonkoff 2010, p. 1). The architecture of a child's brain begins to develop before birth and continues into early adulthood. There are critical and sensitive periods in brain development during which certain skills or traits are more readily developed (Cunha & Heckman 2007, p. 4). Over time, the developing brain's architecture stabilises, making it harder to modify. This means that interventions in later life are less likely to be effective (Mustard 2005, p. 7).

The environment and experiences that are encountered by a child are critical to healthy brain development, particularly in the early years. Children who grow up in stimulating, nurturing and non-violent environments are more likely to thrive in all aspects of their lives. In contrast, a child who is exposed to recurrent abuse or neglect early in life can experience persistent elevations of stress hormones and altered levels of key brain chemicals that disrupt the architecture and chemistry of their developing brain (Centre on the Developing Child 2007, p. 9). This has consequences for a child's future learning, social and emotional development, and physical and mental health, as well as having significant costs to society (COAG 2009a, p. 8). As shown in Chapter 2, the peak age for child abuse is in the first year of life, during precisely the period when the child's brain is most vulnerable.

Most of the evidence regarding the effectiveness of early intervention services comes from overseas programs focusing on vulnerable children in the early years. This means there is relatively little evidence about what works in an Australian context. Table 1 in Appendix 8 summarises some key early intervention programs that have been extensively evaluated.

A number of countries have implemented various forms of nurse home visiting (NHV) programs. In 1977 the United States (US) Nurse-Family Partnership pioneered an intensive, long-term, high-quality model of home visits by public health nurses to support low-income first-time pregnant women and mothers to foster emotional attunement and non-violent parenting. In efficacy trials the model has been found to reduce child abuse and neglect, criminal behaviour and welfare dependency for up to 15 years after the birth of the child (Olds et al. 1997). The cumulative benefits of the program after 15 years are estimated to be up to five times greater than its cost (Karoly et al. 2005, p. 109).

Reviews of other NHV programs internationally have also found that they can produce benefits for children and parents, such as improved parental attitudes and capacity and better quality parent-child interactions, but the size of these benefits is significantly more modest under standard service conditions. Other main conclusions from these reviews include:

- Implementing NHV programs is difficult. There are low participation rates for families invited to enrol and significant proportions of families leave the programs before completion;
- Results from NHV programs and the retention of participants may be improved if the programs were more flexible in delivering scheduled activities according to parental needs;
- The results of long-term studies of NHV programs vary depending on the program sites, the evaluation methodologies employed, and the demographic characteristics of participating families; and
- Fostering close linkages between NHV and other programs may have a multiplier effect, improving individual effectiveness of linked programs (Sawyer et al. 2010, p. 45).

Programs such as the Perry Pre-School Program and the Abecedarian Project in the US have shown that high-quality early childhood education and family support programs for vulnerable children and their parents also deliver long-term benefits to the child, family and society. Longitudinal studies have demonstrated that these programs have resulted in sustained improvements in behaviour, reduced criminal and antisocial activity, better educational and employment outcomes, reduced intergenerational abuse, and a lower long-term burden on the health system.

The average economic benefits of early education programs for three and four year olds from low-income families has been found to be almost two and a half times the initial investment. These benefits take the form of improved educational attainment, reduced crime and fewer instances of child abuse and neglect (Aos et al. 2004, p. 6). Within this overall figure, there is substantial variation. Some early education programs have been found to yield much higher benefit-to-cost ratios, while the benefits of others are exceeded by their costs.

In Australia, the New South Wales Brighter Futures program has been found to significantly reduce harm reports and the likelihood of children going into out-of-home care. The program provides targeted support to pregnant women and families with children aged eight years or younger who face problems such as family violence, parental drug or alcohol misuse or mental health issues (further details are provided in Table 1 in Appendix 8). Support is provided for up to two years and varies according to the family's need. Services may include home visiting, parenting programs and quality children's services. An evaluation found that the program produced savings for the Department of Community Services in terms of avoided costs in responding to harm reports and providing out-of-home care. Families that remained on the program for longer periods of time had better outcomes – but the majority of families stayed on the program for a shorter time (Hilferty et al. 2010, p. 3).

Overall, the evidence establishes that early intervention programs, when well designed and resourced, can have a positive impact on the lives of vulnerable children and families, in a range of areas including educational outcomes, lower welfare dependency, decreased criminal behaviour and improved parenting skills. The US Nurse-Family Partnership program and the New South Wales Brighter Futures program indicate that early intervention programs targeted at vulnerable families can also reduce the incidence of child abuse and neglect. The long-term economic and social benefits of the most effective programs far exceed their costs.

The evidence on the effectiveness of early intervention is strongest for programs for vulnerable families with young children, in particular for home visiting programs and early childhood education programs. This is consistent with the research on the significance of the early years in the development of a child's brain. There is less evidence of the effectiveness of early interventions to support vulnerable older children and young people. However, there is support among researchers, academics and service providers for early intervention focusing on vulnerable children beyond their early years. A key requirement for successful programs is the engagement of families over extended periods.

Caution needs to be exercised when considering whether the results of overseas programs can be successfully replicated in Victoria. The costs and benefits for any given program are specific to the environment in which they are implemented. The demographics of the target population, labour market conditions and local infrastructure are just three examples of important contextual factors that can significantly change the costs and benefits of programs (Allen 2011, p. 33).

Further, the available evidence base is not deep enough to conclusively demonstrate what amount of investment and what mix of programs is necessary to produce improved outcomes. However, programs such as Brighter Futures in New South Wales indicate that programs with longer duration produce greater benefits, if families can continue to be engaged.

Two recent initiatives will help to build a local evidence base about the effectiveness of early intervention programs in Australia. The Australian Intensive Nurse Home Visiting randomised control trial, to be conducted by the Australian Research Alliance for Children and Youth with the Centre for Child and Community Health, will examine the value of a best practice intensive NHV approach as a means to alleviate the impacts of poverty on children's learning abilities. The Effective Early Educational Experiences (E4Kids) study, conducted by The University of Melbourne and Queensland University of Technology, is a five-year longitudinal study of more than 2,800 children living in Victoria and Queensland, which will examine the contributions made by different early childhood education programs to children's learning and development over time.

8.2 Early intervention in Victoria

A number of early intervention programs focusing on vulnerable children and young people have been introduced in Victoria in recent years. Early intervention programs are delivered across the range of sectors that deliver services to vulnerable children and young people. In most cases, these programs have been developed and implemented independently by government departments and agencies as they have sought to pursue their particular policy goals. For example, The Royal Women's Hospital Women's Alcohol and Drug Service (described in Table 4 of Appendix 8) is specifically aimed at pregnant women who use drugs and alcohol. This service operates in a health context by referral and is not integrated into a broader response.

Many Victorian programs have been informed by the evidence from overseas that early interventions can have a positive impact on the lives of vulnerable children and families, and produce long-term benefits for society. The lack of evidence about what early interventions are effective in Australia presents challenges to governments as they seek to support vulnerable children and families. As discussed above, the success of a program for a certain target population in the US, for example, may not be replicated when it is applied in a different economic and social context in Victoria. The intensity and duration of the intervention must also be defined. This has led to agencies implementing a number of initiatives that are small in scale.

Some programs have been introduced as pilot programs or trials in local areas to gather further evidence about their effectiveness in Victoria. Examples of these programs include Tummies to Toddlers, Family Life's Community Bubs and the Children's Protection Society model of child care (all described in Table 3 of Appendix 8).

Universal services, including early childhood services, schools and the public health system, play a key role in identifying children and young people at risk. Services for vulnerable adults, such as drug and alcohol services, mental health services and disability services, are also well placed to identify vulnerable children and families and to respond to their needs. It is important that these services act in a coordinated way to provide holistic support for the full range of needs of vulnerable children and their families.

The *National Framework for Protecting Australia's Children 2009-2020* included a commitment to convene an expert taskforce to develop a common national, cross-sector approach to identifying and responding early to the needs of vulnerable children and families. The taskforce submitted its report to the Commonwealth in 2010, recommending that further work be undertaken to confirm the efficacy and effectiveness of the common approach.

This section describes the role of universal services and specialist adult services in identifying vulnerable children and families, and summarises the early intervention programs that seek to respond to their needs. Specifically, the section examines:

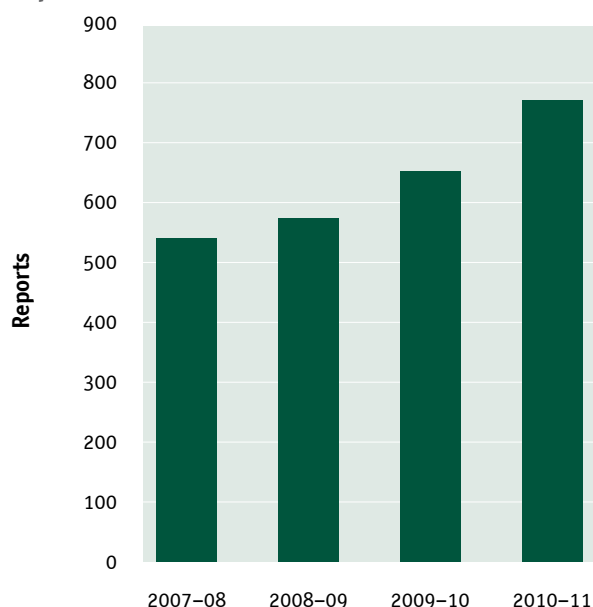
- Pre-birth responses;
- Early childhood services;
- School-based services and programs;
- Youth services;
- Community-based family services including Child FIRST;
- Health services; and
- Specialist adult services.

Section 8.3 then analyses the performance of these services and programs.

Table 8.1 presents a snapshot of Victoria's early intervention programs for vulnerable children and young people and their families. It highlights that responsibility for vulnerable children and young people is shared by the Commonwealth, state and local governments, as well as a range of non-government organisations that deliver services. Within the Victorian Government, responsibility for setting policy, funding and delivering services is shared by the Department of Human Services (DHS), the Department of Education and Early Childhood Development (DEECD) and the Department of Health (DOH).

Table 8.1 also illustrates the range of responses available to address a range of risk factors related to vulnerability as discussed in Chapter 2. The table highlights that the majority of services are focused on limited risk factors, despite the growing acknowledgement that vulnerable children and families are facing increasingly complex and multiple issues. Note that Table 8.1 is representative of the key early intervention programs in Victoria; however, the Inquiry has not attempted to provide an exhaustive list of all Victorian early intervention services for vulnerable children and families.

Figure 8.1 Pre-birth child protection reports, Victoria, 2007–08 to 2010–11



Source: Information provided by DHS

8.2.1 Pre-birth responses

The *Children, Youth and Families Act 2005* (CYF Act) introduced the capacity for a person to make a report to DHS when they have a significant concern before the birth of a child for the wellbeing of a child after the child's birth. These actions are referred to as 'pre-birth reports' and the subsequent service system response are 'pre-birth responses'. The intention of the government when introducing pre-birth reports and pre-birth responses was to provide assistance and support to a pregnant woman to reduce the likelihood that her child, when born, would need to be placed in out-of-home care or be the subject of any protective intervention by the Secretary of DHS. The explanatory memorandum to the Children, Youth and Families Bill 2005 indicated that the principle is one of supportive intervention rather than interference with the rights of any pregnant women.

The number of pre-birth reports received by DHS has increased steadily since the introduction of the legislation (see Figure 8.1). Child and Family Information Referral and Support Teams (Child FIRST) and community-based family service providers have reported that the capacity to refer or report concerns before birth adds significantly to earlier intervention capacity.

This includes the capacity to undertake pre-birth planning meetings, liaise with other services and the extended family to ensure an appropriate support network is in place, make clearer planned decisions and set clear shared expectations with parents about how protective concerns and significant concerns for wellbeing can be overcome to avoid statutory involvement after birth (KPMG 2011b, pp. 106-107).

The Inquiry was unable to uncover any information regarding the outcomes of pre-birth reports. It is not known what support has actually been provided to pregnant women as a result of pre-birth reports, how families have responded to pre-birth reports or how effective pre-birth reports have been in preventing infants coming into out-of-home care. The Inquiry considers this to be an area that requires urgent evaluation – see Recommendation 15 in section 8.4.

8.2.2 Early childhood services

DEECD is responsible for the planning and delivery of early childhood development services in Victoria. These services include universal maternal and child health (MCH) and kindergarten services for all children and enhanced MCH, supported playgroups and Early Start Kindergarten for vulnerable and disadvantaged children and families. In 2010-11 the DEECD budget for early childhood development services was \$405 million (Victorian Auditor-General's Office (VAGO) 2011b, p. ii). Services are provided by local government, community service organisations (CSOs) and private businesses. DHS and DOH are also responsible for other antenatal early intervention programs.

Table 2 in Appendix 8 provides a summary of targeted early childhood services in Victoria. The performance of early childhood services in providing an early intervention response to vulnerable children and young people is examined in section 8.3.1, with the Inquiry concluding that opportunities exist to effectively expand these services to provide better outcomes for vulnerable children and their families.

Table 8.1 Early intervention programs in Victoria, by risk factors addressed

Program	Delivered by	Funded by	Risk factors addressed									
			Child		Parent, family or caregiver						Community	
			Age and gender of the child	Health and disability factors	History of family violence	Situational stress	Alcohol and other substance misuse	Mental health problems	Parental history of abuse	Intellectual disability	Social inclusion and exclusion	Social norms and values
Early childhood services												
Enhanced maternal and child health	Local government	DEECD	✓	✓					✓			✓
Early parenting centres	CSOs	DHS	✓						✓			✓
Early childhood intervention services	DEECD and CSOs	DEECD	✓	✓							✓	
Healthy Mothers, Healthy Babies	Community health agencies	DOH	✓								✓	
Supported playgroups	Local government, CSOs	DEECD							✓		✓	✓
Early Start Kindergarten / Access to early learning	Non-profit and for-profit centres	DEECD	✓	✓							✓	
School supports												
Student support services program	DEECD	DEECD		✓								
Primary welfare officer initiative	DEECD	DEECD		✓								
Student welfare coordinators	DEECD	DEECD		✓								
School focused youth service	DEECD	DEECD		✓							✓	
Youth services												
Finding Solutions	CSOs	DHS	✓	✓								✓
Youth support services	CSOs and a community health agency	City of Melbourne	✓	✓								✓
Reconnect	CSOs	Australian Government	✓	✓								
headspace	CSOs	Australian Government	✓	✓								
Community-based family services												
CHILD FIRST / Community-based family services	CSOs	DHS	✓	✓	✓		✓	✓	✓			✓

Program	Delivered by	Funded by	Risk factors addressed									
			Child		Parent, family or caregiver						Community	
			Age and gender of the child	Health and disability factors	History of family violence	Situational stress	Alcohol and other substance misuse	Mental health problems	Parental history of abuse	Intellectual disability	Social inclusion and exclusion	Social norms and values
Health services												
Child health teams (Community health)	Non-profit agencies	DHS		✓								
Peer Support for Young People	Royal Children’s Hospital	DOH	✓								✓	
Family violence programs	Royal Children’s Hospital	DOH			✓							
Gatehouse Centre	Royal Children’s Hospital	DOH		✓								
Psychiatric mother and baby units	Austin Health, Southern Health, and Mercy Health.	DOH						✓				
Specialist adult services												
Family Drug Help		DOH		✓			✓				✓	
Youth-focused drug and alcohol services	CSOs	DOH	✓	✓								
Kids in Focus (and associated programs)	Odyssey House Victoria	DOH					✓					✓
Specialist child and adolescent mental health services	CSOs	DOH	✓	✓								
Families where a Parent has a Mental Illness (FaPMI)	CSOs	DOH						✓				
Disability services												
Respite	CSOs	DHS		✓						✓		
Flexible support packages	CSOs	DHS		✓						✓		
Individual support packages	CSOs	DHS		✓						✓		

Source: Inquiry analysis (Note: CSOs refers to community service organisations)

Universal services

As described in Chapter 7, Victoria has a strong infrastructure of universal services for infants and children, including the universal MCH service and kindergarten. These provide an accessible and non-stigmatising service for identifying vulnerable children and families who would benefit from early intervention.

The universal MCH service provides 10 'key ages and stages' consultations from birth to 3.5 years, including an initial home visit for all children and their families. MCH nurses assess and monitor the health, growth and development of children, and provide information and advice on breastfeeding, appropriate nutrition, child behaviour, parenting and maternal physical and emotional health and wellbeing. MCH services also run new-parent groups to help parents through the early stages of parenting and to strengthen social supports between parents in a neighbourhood. The vast majority of MCH services are delivered by local government, with DEECD and local government each funding 50 per cent of the cost.

In 2009-10, 99.8 per cent of Victorian newborns received an initial MCH consultation, usually a home visit. This means that Victoria has an exceptional platform for monitoring all children from birth and identifying vulnerable children and families. However, participation in the service is voluntary, and there is a progressive decline in participation as children grow older. The potential of MCH to help address the needs of children and families who would benefit from referral to an early intervention service is not being fully realised. By 18 months, 28 per cent of children do not attend an MCH service for a consultation. By the last consultation at 3.5 years, only 63 per cent of families are still using the service (VAGO 2011b, p. 10).

The decline in participation in MCH heightens the risk that vulnerable children between the ages of 12 months and four years may not be identified until the opportunity for early intervention has passed. As discussed in Chapter 7, the only universal services available to families during these three years are the three MCH visits when the child is aged 18 months, two years and 3.5 years. Children may attend playgroups, long day care or other early childhood education and care services during these years, but participation in these services is far from universal.

Kindergarten is a voluntary and universally available early childhood education program for children in the year before they start school, mostly for children aged four years. The majority of kindergarten programs are run by CSOs in stand-alone centres, with the remainder provided by local councils and private sector operators. DEECD subsidises the cost of four year old kindergarten programs, with remaining costs met by local fundraising and fees paid by families. Families with a concession card, or who have triplets or quadruplets starting at the same time are eligible for a larger fee subsidy that allows the child to attend a standard 10.75 hour per week program for free.

In 2010, 95 per cent of Victorian four year olds participated in a kindergarten program. This strong participation rate makes kindergarten another excellent potential platform for identifying vulnerable children, and for referring them or their families to appropriate services. However, in 2010-11, there were only 62 referrals from kindergartens or preschools to Child FIRST. This represents about 0.1 per cent of children attending four year old kindergarten, and 0.3 per cent of all referrals to Child FIRST. In addition, there were 582 reports made to statutory child protection by child care services and preschool teachers, representing just 1 per cent of all statutory child protection reports.

DEECD is not currently taking full advantage of the strong participation rates in MCH and kindergarten to identify and respond to vulnerable children and families. In 2007 the Auditor-General recommended that the government:

Establish a common statewide database system for early childhood services across the state, including improved monitoring of vulnerable clients to assist in the development of targeted programs in local areas of need (VAGO 2007, p. 5).

This system is yet to be implemented, which means DEECD lacks the capability to systematically identify vulnerable children or track service delivery to individual children. In his 2011 report on early childhood services, the Auditor-General found that DEECD does not sufficiently understand or effectively manage demand for early childhood services:

The department's inability to reliably identify all vulnerable children and families means it does not know the extent to which children are missing out on the benefits of attending targeted services specifically developed and funded to meet their needs (VAGO 2011b, p. vii).

In its submission to the Inquiry, the Municipal Association of Victoria reinforced that there is an opportunity to enhance early intervention in Victoria by resourcing MCH and kindergarten to identify and respond to children and families at risk (Municipal Association of Victoria submission, pp. 4-5).

The Inquiry supports the recommendations made by the Auditor-General in the 2011 report that DEECD develop a better understanding of service demand, particularly for the vulnerable and disadvantaged, by:

- Reviewing its definition of vulnerability to guard against children and families 'slipping through the net';
- Working in partnership with service providers to identify and act to remove barriers to access and participation, especially for the vulnerable and disadvantaged;
- Working in partnership with service providers to identify and act to mitigate the reasons for the fall in attendance at MCH checks after the first visit (VAGO 2011b, p. 36).

The Inquiry notes that DEECD accepted these recommendations and has commenced their implementation. In addition, in Chapter 7 the Inquiry recommends that DEECD provide funding and access to appropriate infrastructure such as kindergartens, MCH services and community playgroups to operate in locations where there are high numbers of vulnerable children and families.

Enhanced maternal and child health

Enhanced MCH is a targeted program delivered by MCH services to families assessed as at risk of poor outcomes, in particular where there is more than one risk factor. Priority is given to families with children aged under 12 months. The service aims to improve the health and wellbeing of children by providing more focused and intensive support than is available through the universal MCH service. A tailored service is provided to each family, which can include parenting advice, home visits, referring the family to specialist services and respite services.

Enhanced MCH services are fully funded by DEECD and delivered by local government. The service is not funded to provide any pre-birth response. In 2009-10, Enhanced MCH services were used by 12,700 families – about 16 per cent of families with a child aged under 12 months. The Auditor-General found that the actual need for Enhanced MCH is likely to exceed the number of available places (VAGO 2011b, p. 12).

The Inquiry examined the utilisation of enhanced MCH services across DHS regions, finding that while a greater number of services are provided in metropolitan regions, the average utilisation rate per family with a child aged under 12 months is higher in non-metropolitan regions. As discussed in Chapter 9, non-metropolitan areas typically have higher rates of statutory child protection reports than metropolitan regions. The Inquiry examined the same data at the local government area (LGA) level, but could not find a strong correlation between the utilisation of enhanced MCH services and statutory child protection reports or vulnerability as measured by the Australian Early Development Index. This indicates DEECD and local governments should endeavour to more closely align the geographical distribution of utilisation of enhanced MCH with the distribution of vulnerability.

Other antenatal and postnatal services

The Healthy Mothers, Healthy Babies program supports disadvantaged or vulnerable pregnant women to access services and improve their health behaviours through the antenatal and perinatal stages (HDG Consulting Group 2011). The program targets women who experience barriers to accessing antenatal care services or who require additional support in pregnancy. The program worker supports the woman throughout her pregnancy, based on what the woman considers her most important priorities. This can include providing health education, promoting healthy behaviours, addressing psychosocial needs, ensuring attendance at antenatal and other relevant services and to generally empower and support the woman. Following birth the worker ensures the mother is linked to MCH and other relevant service providers. DOH funds six community health agencies to deliver the program in eight LGAs in metropolitan Melbourne.

Early parenting centres aim to increase the knowledge, skills and confidence of parents with children from birth to three years who are experiencing acute early parenting difficulties. Services provided include day-stay programs (on or off campus), a residential program, in-home programs and group education or seminars. There are three early parenting centres funded by DHS to deliver services across the state. However, the three centres are all based in metropolitan Melbourne which may limit the availability of service to families living in regional and rural areas.

In recent years the early parenting centres have moved to provide services to more vulnerable infants and their families. This is a welcome shift of focus that will help support those infants and families who will benefit most from an early intervention service. However, due to the limited program budget, more intensive programs, such as residential programs, are now largely confined to statutory child protection clients.

The government has committed \$16 million over four years to establish the Cradle to Kinder program, which will provide pregnant women and vulnerable mothers and their families with intensive antenatal and postnatal assistance and case management. The program commences in pregnancy and continues until the child reaches four years of age. The target group is pregnant women aged under 25 years where a report to statutory child protection has been made regarding their unborn child or where there are a number of indicators of vulnerability. The Inquiry understands that services will be provided at a local catchment level, with Child FIRST being the point of entry to the program. DHS advised the Inquiry that it anticipates that Cradle to Kinder programs will be established in 10 to 14 Child FIRST catchments, with between two and four Aboriginal-specific programs being developed.

Supported playgroups

DEECD's Supported Playgroups and Parent Groups Initiative seeks to engage vulnerable and disadvantaged families with children aged up to four years who may, for a range of reasons, under-utilise or have difficulties accessing universal early childhood services and supports, including community playgroups. The initiative aims to build parents' capacity to support their child's health, development, learning and wellbeing and to increase families' participation and linkages with other early years services. The initiative targets four population groups: Indigenous families; culturally and linguistically diverse families; families affected by disability; and disadvantaged families with complex needs.

Supported playgroups are provided in the 29 municipalities that host Best Start partnerships (see Table 2 in Appendix 8). They are a low cost initiative, with no cost to participating families. Funding is used to support group activities, including employing a qualified worker to facilitate the group. Playgroup Victoria's submission to the Inquiry noted that supported playgroups are a particularly flexible service model, given they can be replicated in any community, including Aboriginal and culturally and linguistically diverse communities, without the need of extensive infrastructure (Playgroup Victoria submission, p. 3).

Targeted preschool programs

Since 2008, Early Start Kindergarten has provided free kindergarten programs for three year old children known to statutory child protection (including those referred directly from statutory child protection to Child FIRST) and three year old Aboriginal and Torres Strait Islander children. The objective is to provide vulnerable three year olds with access to a quality early childhood education and care program that helps with their language and development, social interactions and self-confidence. The program is fully funded by DEECD.

The take up of Early Start Kindergarten by vulnerable children and families has been disappointingly low, particularly among children known to statutory child protection. In 2010, only 463 three year olds accessed the program across Victoria, which represents about 12 per cent of the eligible population. This included 258 Indigenous children and 205 children known to statutory child protection. A DEECD evaluation of the program identified a range of factors for the low take-up including that there were too few kindergartens that could accommodate eligible children; and that the referral and placement arrangements did not work as envisaged (VAGO 2011b, pp. 13-15).

DEECD is exploring new ways to support vulnerable children to access kindergarten. The Access to Early Learning initiative is a new service model that aims to support vulnerable three year old children to participate in early childhood education and care, addressing the barriers to participation in Early Start Kindergarten. Three pilots of the Access to Early Learning model commenced in July 2011. Table 3 in Appendix 8 provides further details about this and other locally based early intervention programs.

The Inquiry understands that DEECD is conducting an evaluation of effective early childhood service provision to vulnerable children, including the Access to Early Learning program. This evaluation will provide valuable information to assist the design of effective early intervention programs in this area.

8.2.3 School-based services and programs

As a universal and compulsory service, schools are uniquely placed to identify vulnerable children and young people, to provide additional support to children in need, and to refer children and their families to other specialist services where appropriate.

Table 2 in Appendix 8 summarises those school-based programs that help identify vulnerable children and provide early intervention supports. The Primary School Nursing Program and the *School Entrant Health Questionnaire* are the main programs that identify vulnerable children, while early intervention supports include the Student Support Services program, the Primary Welfare Office Initiative, student welfare coordinators and the School-Focused Youth Service.

The contribution of school supports to providing an early intervention response to vulnerable children and young people is examined in section 8.3.1. The Inquiry concludes that there is a range of school-based initiatives that support vulnerable students and their families, but there is limited evidence regarding their effectiveness.

Identifying vulnerable children

The Primary School Nursing Program is a free service offered by DEECD to all children attending primary schools in Victoria. Primary school nurses visit schools throughout the year to provide children with the opportunity to have a health assessment, provide information and advice about healthy behaviours and link children and families to community-based health and wellbeing services. The program is designed to identify children with potential health-related learning difficulties and to respond to parent/carer concerns and observations about their child's health and wellbeing.

With the parent's or carer's permission, assessment results may be shared with relevant staff at the school, such as the teacher, principal or student support officers, to provide children with appropriate ongoing support in the school environment.

A *School Entrant Health Questionnaire* is completed by parents or carers during a child's first year of school. The questionnaire records information about the parent or carer's concerns and observations about their child's health and wellbeing. The questionnaire is an important source of information about a child's vulnerability. It records information regarding child and family demographics, the child's general health, dental health, speech and language, service use, behaviour and emotional wellbeing, risk of developmental and behavioural problems and family stress.

In 2010, questionnaires were returned for 57,000 children, representing 87 per cent of children enrolled in Prep.

Primary school nurses review the questionnaires prior to undertaking the child's health assessment. If the nurse has concerns about a child's health after assessing the questionnaire or the child, the nurse will provide the child's parent or carer with information based on the child's needs and may also suggest referring the child to another health professional or agency.

Student Support Services

The Student Support Services program aims to support children and young people in Victorian government schools who are vulnerable, have additional needs or are at risk of disengagement. The program also aims to strengthen the capacity of schools to engage all students in education and improve learning and wellbeing outcomes. Student support services officers are employed by DEECD and include psychologists, guidance officers, speech pathologists, social workers and visiting teachers and other allied health professionals.

The impact of the Student Support Services program has not been evaluated. DEECD conducted an 'extensive' public consultation process regarding the program in 2008 to inform a set of strategies to enhance the program. Strategies included officers working on a school network or sub-regional basis, rather than being allocated to specific schools, in order to provide greater support for students with the greatest need and ensure more effective distribution of services across schools, networks and regions (DEECD 2009b, p. 8).

School satisfaction with student support services has declined markedly in recent years. In 2006-07, 87.9 per cent of schools were satisfied with these services (Victorian Government 2008b, p. 75). By 2010-11, DEECD expected this to have declined to 73.2 per cent. DEECD reported that the lower satisfaction rate is the result of the program undergoing major reform, suggesting that satisfaction with the program may have been affected by principals' perceptions of a reduced role in determining service priorities and allocating resources under the new service model. Service delivery arrangements were being reviewed in 2011, and DEECD predicted satisfaction levels would continue to be down until the revised model was implemented by the end of 2012 (Victorian Government 2011c, p. 181).

Primary Welfare Officer Initiative

The Primary Welfare Officer Initiative aims to enhance the capacity of schools to support students who are at risk of disengagement from school and who are not achieving their educational potential. Primary welfare officers assist schools to promote the resilience of children and their engagement in school. Since 2006, DEECD has employed the equivalent of 256 full-time primary welfare officer positions in 450 Victorian schools identified as having high needs (DEECD 2011a). The government has recently expanded this initiative to provide an additional 150 primary welfare officers over the next three years. In total, 569 schools will receive primary welfare officer funding in 2012. These will be followed by approximately 87 schools in 2013 and 148 schools in 2014.

Evaluations of the Primary Welfare Officer Initiative commissioned by DEECD prior to 2007 concluded that the initiative has increased the capacity of schools to support at-risk students and their families, including by improving links with families and external agencies. The initiative was also found to have had a positive impact on individual students, including by raising self-esteem and reducing incidences of aggressive behaviour (DEECD 2007b, p. 3).

Student welfare coordinators

DEECD provides funds to all government secondary schools to employ student welfare coordinators. The coordinators are responsible for helping students handle issues such as truancy, bullying, drug use and depression. Coordinators work with other welfare professionals and agencies to address student needs. DEECD advised the Inquiry that in most cases student welfare coordinators are likely to be part-time roles, or the funding will be used by schools to provide teacher release to undertake student welfare duties. The total budget for this program is \$12 million per annum, or an average of \$37,500 per school (roughly equivalent to 0.5 effective full-time staff per school). Small schools may receive funding equivalent to around 0.2 EFT (effective full-time). This initiative has not been evaluated in recent years. The Inquiry was unable to uncover any evidence on the degree to which coordinators assist students who are at risk of, or who have experienced, abuse and neglect.

School Focused Youth Service

The School Focused Youth Service is a statewide service that aims to develop a more coordinated and integrated response for young people aged 10 to 18 years, who are at risk of developing behaviours that make them vulnerable to self-harm, disengagement from school, family or community, or who are displaying behaviours that require support and intervention.

The service is an initiative of DEECD, in partnership with the Catholic Education Office and the Association of Independent Schools of Victoria. It adopts a partnership approach to strengthen the capacity of local services, communities and schools to collaborate, develop and better coordinate stronger prevention and early intervention strategies as part of a service continuum for vulnerable children and young people. According to information provided to the Inquiry by DEECD, 45,147 children and young people received a service in 2010-11.

An evaluation of the School Focused Youth Service in 2007 found that the service had positive impacts on young people, including positive changes in behaviours, improved attendance and engagement with school, better peer relationships and communication skills, and more positive attitudes to self, peers, teachers and school. The program was also found to improve knowledge about issues and services in the community and school, and to contribute to the development of partnerships, planning and programs between education and community sectors at the local community level. The evaluation identified a need for further development of quantitative data to highlight program outcomes (DEECD 2007c, p. 5).

8.2.4 Youth services

Young people undergo significant changes as they go through adolescence and increasingly take on adult roles and responsibilities. While many young people manage this transition effectively, others require support. In Victoria a range of early intervention programs and initiatives are in place to support and assist young people who experience difficulties. Such services have the potential to identify and respond to young people subject to abuse or neglect.

Youthcentral is a Victorian Government website for young people aged 12 to 25 years that offers information and advice on a range of issues and access to services.

Finding Solutions is a statewide early intervention program funded by DHS and operated by CSOs, targeting young people of secondary school age and their families who are at immediate risk of being placed in out-of-home care. The program provides mediation and support to young people and their families to assist them in identifying, addressing and resolving issues, behaviours and/or needs that place the relationship 'at risk' of breakdown. The program aims to divert the family and young person from involvement in the statutory child protection and placement system (DHS 2011a).

The Youth Support Service is a statewide service that aims to help young people at risk of entering the youth justice system. The service is funded by DHS and delivered by CSOs. Young people are referred to the Youth Support Service by Victoria Police, youth justice court advisors and agencies providing services to young people. Young people must have had recent contact with Victoria Police but not be a client of Youth Justice or statutory child protection. Participation is voluntary. The service works with the young person to assess their needs and assist them to develop positive life goals and access other support and services as required (DHS 2011a).

Reconnect is a Commonwealth funded community-based early intervention service operated by CSOs that assists young people aged 12 to 18 years who are homeless, or at risk of homelessness, and their families. It assists young people to stabilise their living situation and improve their level of engagement with family, work, education, training and their local community. The Newly Arrived Youth Support Services is incorporated into Reconnect to support young people aged 12 to 21 years who have arrived in Australia in the previous five years, focusing on people entering Australia on humanitarian visas and family visas, and who are homeless or at risk of homelessness.

The National Youth Mental Health Foundation, headspace, operated by Orygen Youth Services helps young people aged 12 to 25 years who are experiencing mental health difficulties and seeking assistance. Headspace provides assistance with: general health; mental health and counselling; education, employment and other services; and alcohol and other drug services. Section 8.2.7 describes a range of other mental health services and drug and alcohol initiatives that are available to vulnerable youth.

These examples, and the youth-focused mental health programs outlined in Table 5 of Appendix 8, highlight that Victoria has a wide range of programs that offer early intervention to vulnerable youth. However, similar to the other service areas discussed in this chapter, these programs have not been recently evaluated, are not necessarily well connected with the broader service system supporting vulnerable children and are not well coordinated with each other and require specialist access arrangements. This lack of coordination and integration leads to less than optimal service delivery for vulnerable youth and their families.

A whole-of-government Youth Partnerships initiative will trial new approaches to bring existing youth service providers together to identify and respond more effectively to disengaged youth. DEECD is responsible for the implementation of this initiative. The initiative aims to better support at-risk young people by improving the coordination and efficiency of services at the local level. The initiative is based in seven locally governed demonstration sites, established across the following LGAs:

- Greater Geelong, Queenscliffe and Surf Coast;
- Yarra Ranges, Maroondah and Knox;
- Frankston and Mornington Peninsula;
- Swan Hill, Gannawarra, Buloke and Mildura;
- Ballarat, Hepburn, Pyrenees, Moorabool, Golden Plains;
- Greater Bendigo, Central Goldfields, Mount Alexander, Campaspe, Macedon Ranges and Loddon; and
- Wyndham and Hobsons Bay.

The Inquiry considers this to be an encouraging initiative to address what is presently an uncoordinated and inefficient service sector. It is to be hoped that any positive changes achieved in the trial sites achieve can be replicated and implemented statewide.

Adolescents are vulnerable to the risk of abuse and neglect. The Inquiry considers that mental health services have a role to play in the identification of and response to young people who have experienced, or are at risk of, child abuse and neglect.

8.2.5 *Community-based family services*

DHS funds the delivery of a range of community-based family services ('family services') to promote the safety, stability and development of vulnerable children, young people and their families, and to build capacity and resilience for children, families and communities (DHS 2011a).

Family services are focused on vulnerable young people and families that:

- Are likely to experience greater challenges because the child or young person's development has been affected by the experience of risk factors and/or cumulative harm; or
- Are at risk of concerns escalating and becoming involved with statutory child protection if problems are not addressed.

The intention is to provide services earlier to protect children and young people and improve family functioning.

Family services include interventions to enhance parenting capacity and skills, parent-child relationships, child development and social connectedness. The interventions provided to a family are determined by an assessment of need. A child and family action plan is developed to determine the goals of intervention for the child and family and details the interventions to be undertaken to address the needs identified (DHS 2011a). Interventions may include counselling, mediation, group work, assertive outreach, parenting skill development, in-home support and referrals to other appropriate services.

DHS engages CSOs to deliver family services on its behalf. As of June 2011, 96 CSOs were funded by DHS to deliver family services, 13 of which are Aboriginal community controlled organisations (ACCOs). Chapter 3 describes the role of CSOs in Victoria's approach to protecting vulnerable children. The process by which DHS registers and monitors CSOs is described in Chapter 21, while the capability of CSOs is examined in Chapter 17.

Child FIRST

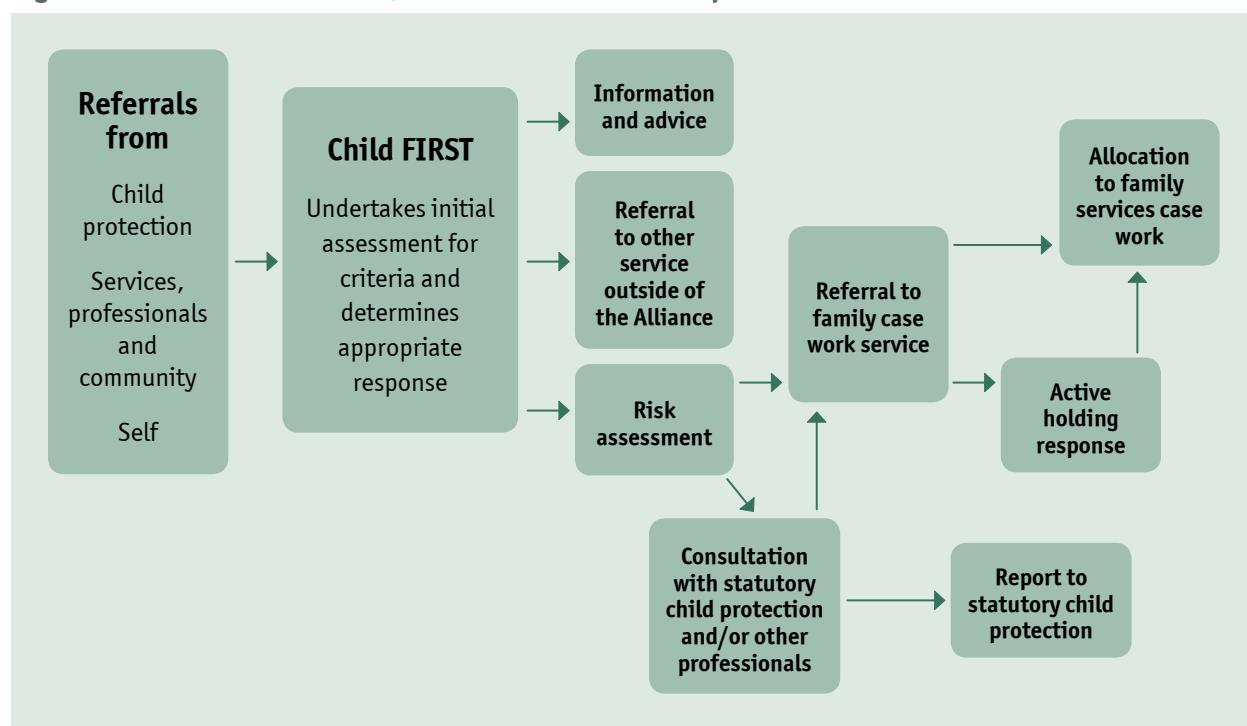
Child FIRST has been established in 24 catchments across Victoria to provide a visible point of entry to local family service providers and other support services for vulnerable families. The first nine Child FIRST sites were established in 2006-07, with all 24 established by 2008-09.

Under section 22 of the CYF Act, the objectives of Child FIRST and family services are to:

- Provide a point of entry into an integrated local service network that is readily accessible by families, that allows for early intervention in support of families and that provides child and family services;
- Receive reports about vulnerable children and families where there are significant concerns about their wellbeing;
- Undertake assessments of needs and risks in relation to children and families to assist in the provision of services to them and in determining if a child is in need of protection;
- Make referrals to other relevant agencies if this is necessary to assist vulnerable children and families;
- Promote and facilitate integrated local service networks working collaboratively to coordinate services and supports to children and families; and
- Provide ongoing services to support vulnerable children and families.

Given these objectives, a key role of Child FIRST is to assess the needs of a family, determine the priority of a service response and allocate families to the organisation within the catchment that is best placed to provide the response, allowing case work to commence at the earliest possible time (KPMG 2009, p. 27). A CSO providing family services will then provide a range of service interventions with a whole-of-family focus, depending on the available services of the particular agency and the needs of the client. The pathway for families engaging with Child FIRST is reflected in Figure 8.2.

Figure 8.2 Child FIRST intake, referral and allocation process



Source: Information provided by DHS

Note that this is a generic model of Child FIRST. Individual Alliance Child FIRST. Models may have variations on this flowchart

Each of the 24 Child FIRST catchments have developed local Alliances, which are a conglomerate of the local family service providers and statutory child protection services. Each Alliance typically includes three or four local family service providers. ACCOs operate in 18 of the 24 catchments. The six catchments that do not have an ACCO providing family services are all rurally based. The Alliances are responsible for operational management, catchment planning and providing service coordination at the sub-regional level. A specific 'lead' CSO in each Alliance provides the Child FIRST intake and referral functions for the Alliance (KPMG 2009, p. 21). These cooperative arrangements are referred to as integrated family services in the sector. The Inquiry refers to these services as community-based child and family services, consistent with the legislation, as the services cannot yet be said to be 'integrated'.

A core function of local Alliances is to develop a catchment plan to guide future service delivery. Informed by data on the needs of vulnerable children and families in the local area, the catchment plan is intended to:

- Lead to strengthened referral processes and pathways;
- Promote earlier intervention and prevention;
- Improve the focus on enabling culturally competent services for Aboriginal people;
- Focus on quality improvement; and
- Improve training and workforce planning.

Context for family services and Child FIRST

Child FIRST and community-based child and family services had their genesis in the 'every child every chance' reforms, which were introduced in the mid-2000s by the Victorian Government in response to a range of factors including:

- A rapid growth in reports to statutory child protection services;
- The impact on the rise in reports to statutory child protection services caused by the introduction of mandatory reporting in Victoria in 1993;
- Recognition that the existing service system did not provide a graduated continuum of responses to vulnerable children and families;
- Families presenting with increasingly complex and multiple problems; and
- Growing evidence regarding the long-term impact of trauma on children.

As a result of these factors, DHS began piloting Family Support Innovation Projects in 2003. These projects had the aim of:

- Reducing demand for statutory child protection by obtaining assistance earlier from community-based services for a significant proportion of families reported to statutory child protection; and
- Minimising progression of families into statutory child protection services, leading to the reduction in growth in demand for high-cost, out-of-home care services.

Additional projects commenced in subsequent years within targeted LGAs. By 2006 Family Support Innovations Projects had been established in 44 LGAs (Thomas et al. 2007, p. 13).

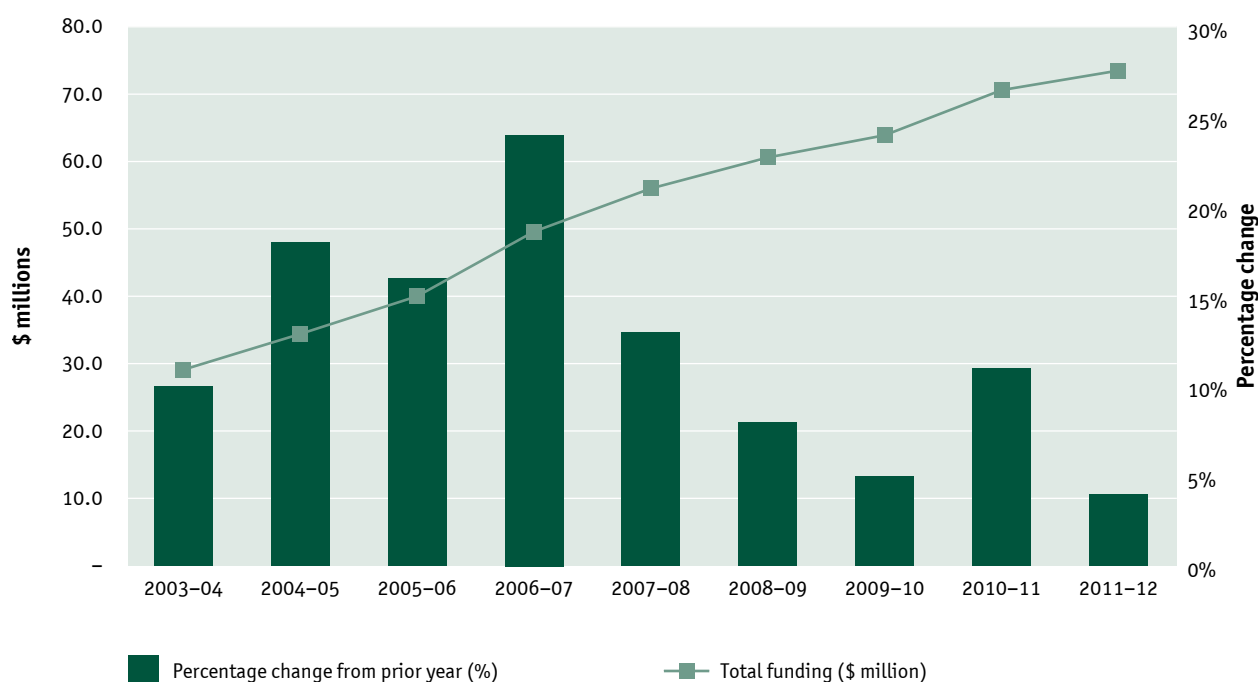
The final evaluation of Family Support Innovation Projects concluded that Victoria's prevention policies and programs, including the Family Support Innovation Projects, were successful in constraining growth in reports and enabling access to early intervention services for families and children (Thomas et al. 2007, p. 7). As a result of this success, DHS proceeded to implement Child FIRST.

The original intention of Child FIRST was to support the further development of a more systematic approach to early intervention within family services, with the legislation emphasising that family support should be targeted at the most vulnerable children and families. The intent was for community-based intake, assessment and referral services to provide a central point within a local community for professionals and other community members to raise significant concerns about the wellbeing of a child or young person. Professionals and members of the public were to have somewhere to go for help, if they had concerns that a family was under stress and would benefit from support. This intervention was to be before problems escalated to the point that the children are placed at risk of significant harm (Parliament of Victoria, Legislative Assembly 2005b, p. 1,371).

With the introduction of Family Support Innovation Projects and then Child FIRST, the Victorian Government substantially increased its investment in family services throughout the 2000s, with notably the most significant proportional increase occurring in 2004-05 and 2006-07. This increase is reflected in Figure 8.3. In 2010 11, 26,461 cases of family services were provided at a cost of \$73.5 million. The number of cases does not equate to the number of families supported because some families may have had multiple episodes of service.

The performance of family services and CHILD First in providing early intervention support for vulnerable children and families is considered in section 8.3.2. Many participants in the Inquiry were of the view that Child FIRST and the establishment of local Alliances of family services has supported improved coordination of family services and better collaboration with statutory child protection. However, because of the lack of comparative information the Inquiry is not able to establish whether this was in fact the case. It is also not yet clear whether Child FIRST has provided a more accessible entry point to family services for vulnerable children, young people and their families. The Inquiry heard that the service system is now prioritising highly vulnerable children and families more than previously, although there are significant demand issues and a lack of evidence regarding the impact of services on client outcomes. There is a need for consistent governance arrangements across catchments to strengthen accountability and better links with other services for vulnerable children and families.

Figure 8.3 DHS funding of Family Services, 2002-03 to 2011-12



Source: Information provided by DHS

8.2.6 Health services

Health service providers come into contact with a large number of children and young people and their families. Accordingly they are well placed to identify vulnerable children and to intervene early to prevent harm and support the wellbeing of both child and family.

DOH is responsible for the planning, policy development, funding and regulation of health service providers and activities that promote and protect Victorians' health. This includes health care services provided through the public hospital system and community health services. The Commonwealth Government has policy and funding responsibility for general practitioners (GPs) and primary health care.

The *Victorian Public Health and Wellbeing Plan 2011-2015* identifies Victoria's public health priorities to 2015. The plan aims to improve the health and wellbeing of all Victorians by engaging communities in prevention, and by strengthening systems for health protection, health promotion and preventative health care across all sectors and all levels of government (DOH 2011b, p. 1). It identifies the need for individuals and health professionals to recognise symptoms and provide access to treatment early in the progression of a disease to improve health outcomes – but does not identify the opportunity to also identify vulnerable children and young people at risk of child abuse or neglect, or other poor outcomes.

The health system has traditionally focused on identifying and treating medical risk. In recent years there has been a move to identify psycho-social risk, as these contribute to medical risks. Reflecting this shift, DOH has established the Vulnerable Children's Program to support health services in the early identification and response to children and young people at risk of child abuse and neglect. It focuses on education and improving communication and collaboration between health, statutory child protection and family services. The level of investment in the program is very low. With less than one full-time equivalent staff member attached to the program and no additional funding available to health services to adopt recommendations or guidelines to improve early intervention services for vulnerable children, the program is inadequately resourced to change behaviour at the service level. The impact of the program has not been evaluated.

The DOH framework for monitoring the performance of health services does not include specific reference to support for vulnerable children, young people and their families, nor does it refer to the role of child- and family-sensitive practice by specialist adult services.

The performance of health services in providing an early intervention response to vulnerable children and young people is examined in section 8.3.1. The Inquiry concludes that Victoria's extensive health system could be better utilised to identify and respond to vulnerable children and their families. In particular, community health services and GPs could be more effectively used.

Public hospitals

Public hospitals are an integral part of improving the health and wellbeing of children and young people. More than 201,000 children and young people (aged up to 24 years) were admitted for public inpatient care across Victoria public hospitals. Further, emergency departments of major public hospitals had an additional, non-admitted, 512,000 presentations of children and young people aged up to 24 years (Australian Institute of Health and Welfare (AIHW) 2011b, pp. 116, 180).

The DOH Vulnerable Children's Program has produced and distributed a best practice framework for public hospitals and acute health care professionals that provides information and guidance on issues relating to children and young people at risk of child abuse and neglect. This framework forms the basis of regular annual reporting by health services on their progress to achieve improved outcomes for vulnerable children.

Hospitals are often the first point of contact for children and young people at suspected risk of harm from child abuse and neglect. This places a special responsibility on hospital staff to identify this risk and reduce it by offering crisis support, ongoing care and referral to specialist intervention services, and by working with other agencies to provide the best combination of services for a particular child and family. Hospital staff made 2,019 reports to statutory child protection and 982 referrals to Child FIRST in 2010-11. This represented 3.6 per cent of all reports to statutory child protection and 5.2 per cent of all referrals to Child FIRST.

The Royal Children's Hospital (RCH) has a special role in responding to the needs of vulnerable children and young people. RCH operates the Centre for Adolescent Health, which includes the Adolescent Forensic Health Service for clients of youth justice and the Young People's Health Service for homeless young people, in addition to clinical services providing general medical services (RCH, Centre for Adolescent Health submission, pp. 3-4).

Other RCH services that provide early intervention support for vulnerable children, young people and their families include:

- A peer support program for young people with significant chronic illness;
- A range of programs for children and their families involved in family violence;
- The Centre for Community Health, which researches the many conditions and common problems faced by children, such as obesity, language and literacy delay, and behavioural concerns; The Family Services Department, which provides family-focused support services including information and support group details for many childhood diseases and chronic illnesses and advice on safety promotion and injury prevention.
- The Social Work Department, which provides social work services via referral to all inpatient wards, medical and surgical units of the hospital, and continues to work with some patients and families after leaving the hospital; and
- The Gatehouse Centre, which offers, among other things, short and longer term counselling for victims of child abuse and their families, assessment and treatment for children and young people with sexually abusive behaviours and problem sexual behaviours, outreach services, and a group work program (RCH 2011; RCH Integrated Mental Health Program, Addressing Family Violence Programs submission, p. 2).

Hospitals also see adult patients whose health status or lifestyle (such as physical or mental health problems or disabilities, and substance misuse) may place their children at risk of harm. In such situations, health care staff have a responsibility to intervene early to ensure the child's safety, as well as to care for and support the parent and family. For example, if a person is being discharged from a specialist treatment facility, it is important to know if they are responsible for the care of children.

There is no evidence to indicate how well health professionals are meeting their responsibilities to identify and respond to vulnerable children and young people. The Inquiry has received anecdotal material from DOH suggesting that the identification and response to risk is highly varied.

One example of good practice in public hospitals is the psychiatric mother and baby units established at the Austin Hospital, Mercy Hospital for Women and Monash Medical Centre. These specialist units provide for the admission of mothers with a mental illness with their babies up to 12 months of age. The mother receives psychiatric assessment as well as treatment, and support to look after her baby and strengthen her relationship with her baby (Post and Antenatal Depression Association 2010). There are similar units in a number of private hospitals.

According to The University of Melbourne and Austin Health, Victoria has more mother and baby units per capita than anywhere else in the world. There is an absence, however, of community programs that act as a stepping stone for those being discharged from units (The University of Melbourne and Austin Health supplementary submission). The government has committed to establishing three new units in rural and regional Victoria. The first of these, to be located at Bendigo Hospital, was funded in the 2011-12 Budget.

Matter for attention 3

The Inquiry draws attention to the fact that an evaluation of the new mother and baby units and the transition of discharged mothers back into the community is needed to inform further investment in this field.

Community health services

Community health services are a network of agencies delivering care from 351 sites spanning every LGA across the state. Services are funded by DOH, the Commonwealth Government and philanthropic sources to deliver an integrated suite of primary health and human services including drug and alcohol, dental, disability, family violence services, home and community care, medical, mental health, and post-acute care. While some of these programs focus on particular client cohorts, services have an overarching strategic intent to prioritise services to more vulnerable population groups, and this is a requirement of their funding agreements with DOH.

Community health services can play a significant role in identifying children, young people and their families who would benefit from early intervention support, and in providing some of those support services. Services aim to promote children's positive development, intervene early to address child health and developmental problems and support parents' active participation in their child's early learning and development (Sabol et al. 2004). In 2009-10, 88 per cent of registered community health clients in Victoria stated they were concession card holders. About 4,900 clients identified as being refugees, and 2,400 clients identified as being from an Aboriginal or Torres Strait Islander background. However, community health services do not collect data on other risk factors presented by clients.

Initiatives and resources within community health that support vulnerable families include:

- 12 child health teams, which provide services to Victorian children from birth to 12 years of age experiencing mild to moderate developmental difficulties and behavioural issues;
- Flexible models of care that allow individual community health services to develop programs that respond to the needs of local vulnerable communities, such as young mothers programs, single dads groups and support for young families;
- A community health counselling policy framework and service standards that include a focus on young people and their families as well as people with mental health issues at risk of other complex issues; and
- A suite of priority tools to enable those most in need to access services and receive help.

At present there is a lack of data about how community health services are performing in supporting vulnerable children and young people and their families. The role of community health services with vulnerable families is not prescribed or monitored. There is no comprehensive data about how many vulnerable families receive support from services.

Matter for attention 4

The Inquiry draws the government's attention to the fact that the development of assessment tools, planning for services and resource allocations in relation to services for vulnerable children, young people and their families, is occurring independently of other government initiatives to support vulnerable families. The early intervention potential of community health services to reduce the vulnerability of children and young people needs further consideration.

General practitioners

GPs are the first point of contact for medical care and referral in Victoria. In 2009-10 there were 1,691 general practices in Victoria and 6,007 general practitioners (GPs) (Carne et al. 2011, p. 11). This broad coverage means that GPs are well placed to identify vulnerable children, young people and families who would benefit from early intervention programs. However, there is no available data to illustrate the support provided by GPs to vulnerable children and families.

Research has been undertaken to study factors that influence the willingness and readiness of GPs to undertake health assessments for children entering out-of-home care. This study found significant barriers for GPs undertaking these assessments. These barriers include: practice system challenges; lack of awareness of the particular health needs of the group of children; lack of relationships with statutory child protection services; difficulties with 'red tape' burdens when interacting with a government body; potential medico-legal risks; and competing workload pressures (Webster & Temple-Smith 2010, p. 299).

Similar challenges may apply to expanding the role of GPs in identifying and supporting children, young people and their families who would benefit from targeted early intervention. Further, GPs are independent, autonomous small business professionals, so their priorities may not easily align with government policy directions and priorities. While these are not necessarily insurmountable barriers to greater use of GPs in this area, they are significant. The Victorian Forensic Paediatric Medical Service's submission (p. 8) to the Inquiry calls for more education of GPs and other health professionals regarding the early identification of the 'at-risk' target group and better involvement of extended families and neighbourhood supports.

8.2.7 Specialist adult services

Victoria offers a broad range of specialist services to support vulnerable adults. Traditionally, the role of professionals working in specialist adult services has been to focus on the needs of the adult client. A range of adult clients may be impacted by child abuse and neglect, including having been victims of abuse and neglect themselves.

Professionals also see adults whose children may be at risk because of the parent's health or social problems. As discussed in Chapter 2, parent, family or caregiver characteristics can influence whether a child is at risk of abuse and neglect. In particular, evidence has confirmed that the presence of poverty, family violence, substance misuse, mental health issues, intergenerational abuse and parent or caregiver disability heighten the risk of abuse and neglect.

This section provides some examples of specialist adult services in Victoria that adopt child and family-sensitive practice or otherwise seek to accommodate the needs of children, focusing on services that are particularly relevant to supporting vulnerable children, young people and their families who are at risk of child abuse and neglect, including alcohol and drugs services, mental health services, disability services and housing. Other relevant services not examined by the Inquiry include problem gambling, financial counselling and correctional services.

The performance of specialist adult services in responding to the needs of vulnerable children and young people is examined in section 8.3.3. The Inquiry concludes that services are not consistently identifying vulnerable children or delivering services that respond to their needs. While promising programs exist, they are varied, not coordinated and are without a simple, visible point of entry.

Alcohol and drug services

Alcohol and drug services aim to prevent and reduce the harm to individuals, families and communities associated with alcohol and other drug misuse. Programs include prevention initiatives aimed at the general community, as well as early interventions, treatment and support for people experiencing substance misuse and their carers and family members. More than 27,000 Victorians enter government-funded alcohol and drug treatment programs each year (VAGO 2011d, p. 1). DOH is responsible for Victoria's alcohol and drug program and funds CSOs, community health services and health services to deliver the programs. Table 4 in Appendix 8 provides a brief description of alcohol and drug resources and treatment services available in Victoria.

Alcohol and drug services can contribute to reducing child abuse and neglect by reducing harm to individuals and families associated with alcohol and drug misuse by both parents and young people. In 2009-10, about one-third of clients of alcohol treatment programs had dependent children (VAGO 2011d, p. 5). The prevalence of alcohol and drug use among parents is described in Chapter 2.

Family Drug Help is a service for people concerned about a friend or relative using alcohol or other drugs. Family Drug Help aims to provide ongoing help to families to reduce the isolation and stigma often associated with a family members misuse and provide non-judgmental, empathic support, as well as accurate information on alcohol and drugs and treatment options.

In addition, a range of services are available specifically to reduce alcohol and drug misuse among young people, including youth outreach and support, residential and home-based withdrawal services, youth residential rehabilitation and youth supported accommodation. The Parent Support Program supports parents and families of drug users and assists them to respond effectively to adolescents and other family members with a drug problem.

While there are supports in place for the adult relatives of a young person with a alcohol and drug problem, to date there has been little recognition of the needs of children whose parents have a problem. One of the few examples is the alcohol and drug residential rehabilitation program provided for parents and their children by Odyssey House. The agency provides a range of services including: home-based support to parents and children with the most intractable problems through the Kids in Focus program; supported accommodation, which caters for parents and children; the Family Eclipse program, a family inclusive intervention for young people aged 16 to 24 years with mental health and drug issues and their families; and the Stonnington Youth Precinct that brings together a number of services including local government to offer wraparound, coordinated services to young people experiencing alcohol and other drug issues.

The Young Parents Program supports young parents or pregnant women aged 12 to 25 years with substance use issues, whose children are likely to become subject to statutory child protection reports. Through intensive case work and support, the program aims to protect the children in the family and enhance participants' parenting capacity by providing family support and drug treatment simultaneously (YSAS submission, p. 6).

Mental health services

Mental health services can help to reduce the risk of child abuse and neglect. A correlation exists between parents who experience mental illness and child abuse and neglect. Estimates of all children in families with parental mental illness are 23.3 per cent (when not constrained by level of mental illness) and 1.3 per cent where the illness is severe (Maybery et al. 2009, p. 24). Services that work to identify and treat children, young people and parents for mental illness can have an impact in reducing the risk of abuse and neglect. Further, services that work with the whole family have the additional benefit of addressing the range of compounding issues that mental illness can impose upon a family.

DOH is responsible for Victoria's specialist public mental health system. Specialist services for children and adolescents, adults and aged persons are delivered by area-based mental health services. Information provided to the Inquiry by DOH indicated that the redesign of specialist mental health care for children and young people and improving outcomes for vulnerable families where a parent has a mental illness are current priorities. Table 5 in Appendix 8 provides a brief description of early intervention mental health services available in Victoria.

Specialist child and adolescent mental health services are provided for children and young people up to the age of 18 years. Early intervention mental health services for children and young people include:

- Integrated therapeutic and educational day programs for young people with behavioural difficulties, emotional problems such as severe depression or anxiety, emerging personality difficulties or a severe mental illness such as early psychosis;
- The Child and Adolescent Area Mental Health Services (CAMHS) and Schools: Early Access program, which aims to reduce the prevalence of conduct disorder in children by delivering sustainable evidence-based interventions in the early years of school and within the school setting. The target population for the initiative is young children displaying challenging or difficult behaviours and/or have conduct disorder in Prep to Grade 3 in mainstream primary schools; and
- The Child and Youth Mental Health Service for children and young people aged under 25 years is being piloted by Alfred Health. The redesigned service model includes a new Youth Early Intervention Team that provides or facilitates a range of services for young people where they are needed through outreach and collaboration with other agencies.

The Families where a Parent has a Mental Illness (FaPMI) strategy is an example of an early intervention initiative to enhance capacity in mental health specialist services, family services and other services to better provide for vulnerable families. The strategy focuses on vulnerable families who are being supported by community-based child and family services and who may have co-occurring drug and alcohol issues as well as parental mental illness. FaPMI coordinators work with mental health services, families and other service providers with the aim of reducing the impact of parental mental illness on all family members through timely, coordinated, preventative and supportive action. Limited brokerage funding is available to support families to engage with other services.

DOH has advised that the budget for the FaPMI initiative in 2010-11 is \$1.3 million. Currently only half of adult mental health services are funding a FaPMI coordinator position. Where FaPMI coordinators exist, services are better linked. Adult mental health clients are more readily identified as parents and family needs are assessed and addressed by clear referral processes.

The FaPMI initiative has not been formally evaluated. However, a progress review by La Trobe University and the Bouverie Centre for DOH suggests that FaPMI coordinators provide an identifiable and accessible point of contact for services outside mental health, consequently promoting collaboration and reducing silos in service delivery systems (Bouverie Centre, La Trobe University 2011, p. 20).

Matter for attention 5

The Families where a Parent has a Mental Illness strategy is a promising initiative that should be extended to operate in all adult mental services. This warrants further consideration by the Department of Health.

Disability services

As discussed in Chapter 2, children with a disability and parents with an intellectual disability are more likely to come into contact with statutory child protection services. This means that, like alcohol and drug services and mental health services, disability services have the potential to identify and provide early interventions to reduce the risk of child abuse and neglect.

DHS funds CSOs to deliver direct support and care to people with an acquired brain injury or an intellectual, physical, sensory or neurological disability in Victoria. DHS also directly provides some care and support services to people with a range of disabilities.

These services include: case management to assist people achieve their goals, become more independent and active in community life; respite services to provide short-term and time-limited breaks on a regular, occasional or emergency basis; flexible support packages to assist children and adults with a disability to maintain family networks, access community activities, enhance independence and reduce the need for more intensive services; individual support packages allocated to a child or adult with a disability to purchase supports to meet their ongoing disability needs; and the Aids and Equipment Program, which assists people with permanent or long-term disabilities to enhance independence in their own home, facilitate their participation in the community and support families and carers.

There are further localised programs in some DHS regions focused on parents with a disability and families with a child with a disability.

A challenge for the successful use of disability services to provide early intervention support for vulnerable children can be the reluctance of parents with a disability to engage with these services. The Victorian Disability Services Commissioner noted that parents with a disability can be fearful of seeking assistance, and understate their need for support (Disability Services Commissioner Victoria submission, p. 4).

Housing

DHS provides public and social housing and support for low-income Victorians, focusing on those most in need. Each year DHS provides housing services to approximately 63,000 public tenant households across Victoria. In June 2011 there were about 17,600 families with children living in public housing (unpublished DHS data). About 16,400 families with children were waiting for public housing in June 2010 (2011 data not yet available).

The provision of public housing can be an early intervention strategy for children and young people at risk of abuse and neglect. A constant theme reiterated through the consultation and submission phase of the Inquiry was the importance of housing in addressing the needs of vulnerable families and the prevalent shortage of available public housing:

By any measure ... the service infrastructure problem in most urgent need of redress for vulnerable children and young people is the lack of affordable housing. The inability of successive governments to provide for this most basic need has been particularly damaging for the children affected (Good Shepherd Youth and Family Service submission, p. 14).

This was also a theme that was specifically highlighted for Aboriginal communities:

There are many families I have seen over the years that are on waiting lists for accommodation. Some request medical certificates justifying to be of a high priority. In my opinion they are all of high priority - safe accommodation is a basic human right. Most families and individuals need to access emergency accommodation at a time of financial and personal crisis. This is a very real time of risk and we should be doing all possible to support them at this time (Victorian Aboriginal Health Service Co-operative submission, p. 6).

The Supported Accommodation Assistance Program is a joint Commonwealth, state and territory government initiative that provides funding for services to help people who are homeless or at risk of homelessness, including women and children experiencing family violence.

Services include crisis accommodation, transitional support, homeless persons support centres and telephone information and referral services. Transitional Housing Management is a related program that offers housing information and referral, crisis and transitional housing and the provision of financial assistance to households in crisis.

Children and young people represented 45 per cent of people in the Supported Accommodation Assistance Program in Victoria in 2009-10. A total of 29,200 children and young people were supported. This included 3,500 direct clients (9 per cent of all clients) and 25,700 children accompanying clients. Overall, 2.3 per cent of Victorian children and young people aged 0 to 17 years were provided accommodation and support by the program (AIHW 2011d, pp. 12-13).

DHS provides a number of homelessness support and assistance programs directed towards vulnerable children and young people. These are summarised in Table 6 of Appendix 8. A number of these programs are funded by the *National Partnership Agreement on Homelessness*, under which the Commonwealth and Victorian governments have contributed \$209.7 million to Victoria over the five years to 2012-13 (Ministerial Council for Federal Financial Relations 2009, p. 11). DHS has advised the Inquiry that it is difficult to collect the data needed to measure progress against the homelessness outcomes identified in the National Partnership.

There is some progress being made by housing services to collaborate with other sector programs, such as family violence and young people leaving care. However, housing availability remains a key issue for vulnerable children and their families.

8.3 Performance of current arrangements

In submissions to and consultations with the Inquiry, stakeholders provided near unanimous support for the use of early intervention to support vulnerable children, young people and families. Stakeholders consistently put to the Inquiry that a greater role for early intervention and prevention is needed to improve the current system response to child abuse and neglect. For example, the joint submission by Anglicare Victoria, Berry Street, MacKillop Family Services, The Salvation Army, Victorian Aboriginal Child Care Agency (VACCA) and the Centre for Excellence in Child and Family Welfare (Joint CSO submission) (p. 42) contended that greater expansion and embedment of early intervention will result in the best gains for vulnerable children and their families, and the whole community, by reducing the need for the government to continue to grow investment in statutory child protection services.

Victoria has a substantial range of early intervention programs that are directed at identifying children, young people and their families who are at risk, and then providing support to these families to reduce the incidence of child abuse and neglect.

While there are many individual programs across sectors, the Inquiry considers that they do not come together to form a comprehensive, coherent and coordinated system of early interventions that addresses the needs of vulnerable children and their families. Within the Victorian Government, DHS, DEECD and DOH each deliver or fund a set of early intervention programs to target groups, consistent with their particular policy goals. There is an absence of holistic service planning and provision that meets the diverse needs of the particular child or young person. Chapter 6 recommends that this be addressed through the development of a Vulnerable Children and Families Strategy.

A more coordinated approach to providing early intervention support for vulnerable children will require better collection and coordination of data about vulnerable children. The information management systems supporting programs and services for vulnerable children are separate and disparate. Data quality is variable and in some cases systems have not kept up with modern business processes or government requirements.

The shortcomings of existing data systems and practices mean agencies may not identify all vulnerable children and young people who could benefit from early intervention services. This means that government is failing to provide all vulnerable children, young people and their families with the support they need to decrease the risk of abuse and neglect. Agencies are often not held accountable for the support they provide, with performance measures tending to focus on outputs rather than child outcomes.

Related to these data issues, Victoria's early intervention efforts are hampered by a lack of evidence on what interventions work. Agencies have largely relied on the evidence of the effectiveness of overseas programs when designing interventions for vulnerable Victorians. As discussed in section 8.1.2, there is a range of factors that could inhibit the successful replication of a program in another economic and social context.

Given the lack of local evidence, it is concerning that many of Victoria's early intervention programs have not been rigorously evaluated. Where local evaluations do exist, the results are generally promising, but the findings are far less conclusive than the extensive, longitudinal evaluations of the international models utilising randomised control groups.

A rigorous evaluation should be an essential feature of any future early intervention initiatives funded by governments.

8.3.1 *Performance of targeted programs linked to universal services*

This section considers the performance of early childhood services, school supports and health services in identifying and responding to the needs of vulnerable children and their families.

Early childhood services

An effective system of early childhood supports for vulnerable children is critical given the importance of the early years to a child's development, and the fact that most reports of abuse and neglect occur in the early years.

Due to its inability to record data on individual children, DEECD does not know how many vulnerable children are missing out on this important service and, potentially, from not being identified as vulnerable until the opportunity for early intervention has passed. As discussed in section 8.2.2, the Inquiry supports the recommendations made in the recent Auditor-General's report on this issue, and recommends DEECD implement them by the end of 2012. The shared funding of MCH between local and state government raises a further potential concern regarding access in lower income municipalities that have less revenue-raising capacity but a relatively larger population of vulnerable families.

To further develop the use of MCH for early intervention, there may be a need to increase the capacity of the enhanced MCH service and strengthen the referral relationship from MCH nurses to other programs focused on supporting vulnerable children. MCH nurses accounted for 4.4 per cent of all referrals to Child FIRST and family services in 2010–11 (unpublished DHS data). It is unclear whether all vulnerable children and their families are being provided with a tailored response to whatever service is most suitable, including referral to Child FIRST or statutory child protection, by all MCH nurses. In order to properly identify all families who would benefit from early intervention supports, there may be a need to develop the ability of MCH nurses to identify and respond to all relevant risk factors. The Inquiry considers that this warrants attention by government.

Families with one or more of a broad range of risk factors are currently eligible to receive an enhanced MCH service. Eligible families include: those with drug and alcohol, mental health or family violence issues; families known to statutory child protection; homeless families; unsupported parents under 24 years of age; low income, socially isolated, single-parent families; families with significant parent/baby bonding and attachment issues; parents with an intellectual disability; children with a physical or intellectual disability; and infants at

increased medical risk due to prematurity, low birth-weight, drug dependency and failure to thrive (DHS 2003a, p. 6). When DEECD reviews its definition of vulnerability, as recommended by the Auditor-General, it will be important that the eligibility criteria for enhanced MCH remain sufficiently broad to include all children and families at risk of poor outcomes. The need for the enhanced MCH provision to be aligned with the concentration of vulnerable children and families is addressed by Recommendation 7 in Chapter 7.

Victoria's existing antenatal and early childhood programs provides a solid base for further investment in early intervention to support the needs of vulnerable children. There is insufficient evidence, however, of the effectiveness of these programs in improving child outcomes. In some cases departments have not put in place the data systems to support the regular monitoring and evaluation of their performance.

The Inquiry considers early parenting centres to be a particularly valuable initiative that should be expanded to reach a broader range of vulnerable families. In particular it would be beneficial if the more intensive residential programs were expanded so they are available to families with multiple risk factors but not yet known to statutory child protection. This would require an improvement in the access of families living in outer Melbourne suburbs, regional and rural areas.

The range of targeted services is potentially difficult for vulnerable families to access and navigate. Programs have been implemented independently over time to address specific objectives rather than as a comprehensive and coherent suite of initiatives to meet the needs of children and their families. Programs are not integrated across sectors, and there is some duplication in their objectives. A number of programs are being delivered on a pilot basis, which means there is not a consistent coverage of services across the state.

Recommendation 11

The Department of Education and Early Childhood Development should implement the recommendations from the Auditor-General's report on early childhood services by the end of 2012.

Recommendation 12

The Government should fund the expansion of early parenting centres to provide services to a greater range of vulnerable families and to improve access to families living in outer Melbourne, regional and rural areas.

School supports

The Primary School Nursing Program and the *School Entrant Health Questionnaire* are important universal programs that can help to identify vulnerable children in the first year of school. Information provided by DEECD to the Inquiry indicates that more could be done to use *School Entrant Health Questionnaire* data to develop school-based programs that meet the needs of vulnerable children. At present there is a range of school supports that support vulnerable students and their families, but there is limited evidence regarding their effectiveness. The Inquiry recommends that DEECD undertake a comprehensive evaluation of these programs.

There are no further universal assessments of a child's health and wellbeing as children grow older. The Inquiry considers that there would be merit in a population health and wellbeing questionnaire of students as they make the transition from childhood to adolescence. In the first instance a pilot questionnaire could be undertaken in disadvantaged government schools. Data could be used to identify vulnerable young people in need of additional support, and to inform the development of school-based programs that meet the needs of vulnerable students.

Recommendation 13

The Department of Education and Early Childhood Development should improve its capacity to respond to the needs of vulnerable children and young people by:

- Undertaking a comprehensive evaluation of whether existing school-based programs are meeting the needs of vulnerable children and young people; and
- Introducing a population health and wellbeing questionnaire of students as they make the transition from childhood to adolescence, and publishing the outcomes in *The state of Victoria's children* report.

Health services

Victoria has an extensive public health system that could be better utilised to identify and respond to vulnerable children, young people and their families. In particular, community health services and GPs have a potentially important role to play. The presence of community health services and GPs in every LGA presents an opportunity for a place-based approach to early intervention. However, as in other sectors, there is insufficient data collected and reported regarding vulnerable children and young people involved with health services.

The recent *Victorian Public Health and Wellbeing Plan 2011-2015* states that:

Currently, many prevention programs and organisations (government and non-government) delivering prevention interventions and services operate in isolation from one another, resulting in duplication of effort, and an inefficient use of available staffing and funding resources (DOH 2011b, p. 32).

There is a need to clarify and monitor the responsibilities of health professionals regarding support for vulnerable children. A focus on vulnerable families and child- and family-sensitive practice should be added to DOH's framework for monitoring the performance of health services.

DOH's Vulnerable Children's Program is a welcome initiative that could support health services to identify and respond to children at risk of child abuse and neglect. However, there needs to be a substantial increase in investment in the program if its goals are to be realised. The program requires sufficient resources to drive change in practice in health services to ensure a stronger focus on identifying the full range of risk factors to children and young people. The Inquiry's recommendations regarding this issue are in section 8.4.

The development of specific early intervention programs within community health services is promising; however the objectives of these programs remain vague. There is a lack of data to assess whether the programs are effective in the targeting and engagement of vulnerable children, young people and families at risk of child abuse and neglect.

Recommendation 14

The Department of Health should amend the framework for monitoring the performance of health services to hold services accountable for support they provide to vulnerable children and families, consistent with their responsibilities under the recommended whole-of-government Vulnerable Children and Families Strategy.

8.3.2 Performance of community-based family services and Child FIRST

Child FIRST and family services were the subject of much comment throughout the Inquiry's consultations. Child FIRST's performance, and perceived success, is largely seen in the context of the family service system prior to its introduction, which was regarded as uncoordinated, difficult to access for families and dramatically under-resourced (Mr Bonnice, St Luke's Anglicare, Bendigo Public Sitting).

DHS engaged KPMG to evaluate the 2007 child and family service system reforms, including the implementation of Child FIRST and family services. The final report of the evaluation of Child FIRST and family services was published by DHS in February 2011.

The Inquiry has reservations about some of the findings reached by KPMG. However, it is not the purpose of the Inquiry to undertake an alternative program evaluation, nor to present a critique of the KPMG evaluation. Instead, this section presents the Inquiry's observations and findings on the performance of Child FIRST and family services, based on the evidence presented in the KPMG report, more recent data made available to the Inquiry, and the views of stakeholders as presented to the Inquiry in submissions and consultations.

In summary, the Inquiry has found that:

- While Child FIRST is broadly considered by agencies to have provided a more accessible entry point to family services compared with previous arrangements, the evidence regarding this is not yet conclusive;
- Many participants in the Inquiry were of the view that Child FIRST and the establishment of local Alliances of family services has supported better integration of family services at the local level than previously, but the Inquiry found that not all Alliances have undertaken effective catchment planning;
- Many participants to the Inquiry were of the view that local Alliances have also contributed to better collaboration and coordination between family services and statutory child protection than previously. However, the Inquiry found that there is a need for better links between family services and specialist adult services, health services, early childhood services and schools;
- Many participants to the Inquiry were of the view that Child FIRST and family services are prioritising highly vulnerable clients to receive services more than previously, but the Inquiry found that there are significant challenges to meet demand for services from families who are at lower risk. In some catchments, there are insufficient family services to meet the needs of vulnerable families;
- There is a lack of evidence on the impact of Child FIRST and family services on outcomes for individual vulnerable children and their families. There is also insufficient evidence to demonstrate that the introduction of Child FIRST has been an effective early intervention by preventing clients from becoming known to statutory child protection; and
- The governance arrangements for Child FIRST Alliances do not provide sufficient accountability for the extent to which the needs of vulnerable children and families in a given Child FIRST catchment are being met. There are also concerns about the sustainability of some Alliances.

Governance arrangements

Section 8.2.5 describes how family services in each of the 24 Child FIRST catchments are governed by local Alliances. Alliances are responsible for operational management, catchment planning and service coordination but have no role in monitoring quality of service provision or achieving client outcomes. Each agency remains autonomous in relation to its accountability for the delivery of services. The Inquiry considers these arrangements to be unsatisfactory because there is an absence of responsibility and accountability at the catchment level for meeting the full range of vulnerable children's and families' needs.

There is a risk that the reliance on local governance arrangements could reduce statewide consistency and public accountability if DHS does not provide Alliances with sufficient guidance and support.

KPMG found there is no consistent approach across Alliances to determining eligibility for family services. The use of different intake and initial assessment tools may reduce the consistency of determining the eligibility and priority level of vulnerable children and families. This would impede the capacity of DHS to ensure vulnerable families have equitable access to family services across the state (KPMG 2011b, p. xii).

The responsibilities of the 'lead' CSO in each Alliance for intake, initial assessment and facilitating an appropriate service response were documented in DHS' request for submissions from CSOs to deliver family services including Child FIRST. These responsibilities are not, however, clearly articulated in the statewide 'shell agreement' for statutory child protection and family services, nor are they specified in DHS' service agreements with lead CSOs. Neither document includes appropriate performance measures for lead CSOs. This is a significant gap in the governance arrangements for Child FIRST and family services, which restricts the ability of DHS to hold lead CSOs to account for meeting their responsibilities.

Of further concern is KPMG's finding that a minority of Alliances are showing early warning signs that they may not be sustainable, such as declining commitment by CSO senior managers to Alliance governance structures. Similarly, capacity constraints are limiting the involvement of some ACCOs in Alliances. KPMG contends that it is likely that more Alliances will face these challenges unless DHS puts in place greater supports for Alliance sustainability (KPMG 2011b, p. xi).

DHS has advised that it is considering a range of options to address these challenges including partnership checks, increased clarity regarding the role of DHS within Alliances, resourcing Alliance project officers and improving ACCO involvement in Alliances.

An accessible entry point

A primary objective of the Child FIRST reforms was to provide a readily accessible point of entry into an integrated network of family services. Prior to the introduction of the 'every child every chance' reforms in the mid-2000s, entry into the family services sector occurred at individual CSO level. As families and professionals did not always know the type of service offered by a particular agency, statutory child protection intake had become the major pathway by which families could gain access to family services and supports (KPMG 2011a, p. 33).

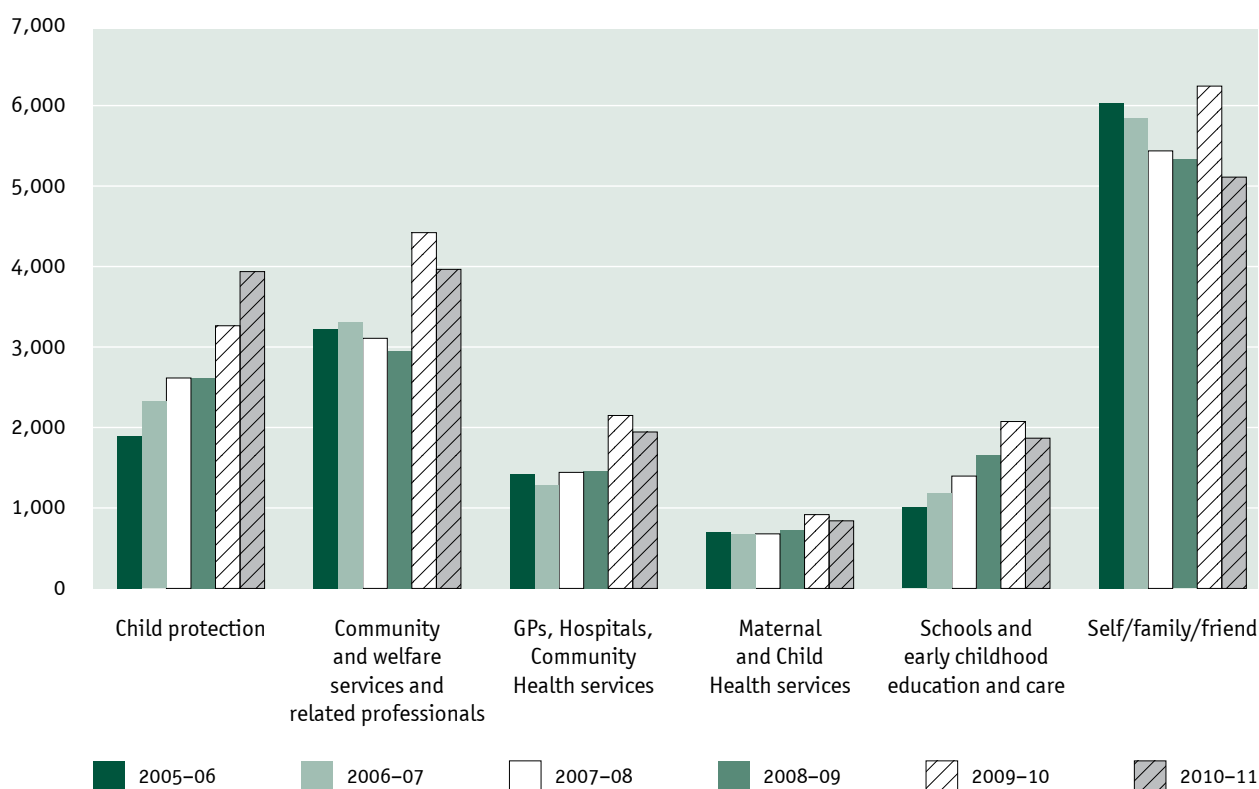
Several CSO providers of family services reported to the Inquiry that the introduction of Child FIRST has increased the visibility of family services:

As a visible point of entry the Child FIRST model has improved pathways to support vulnerable children, young people and families (MacKillop Family Services submission, p. 29).

The changes that have been implemented have greatly improved access for families through the Child FIRST model. Whilst Child FIRST is a challenging model to deliver and maintain it has been one of the most significant and positive service developments to have occurred in recent times (St Luke's Anglicare submission, p. 11).

The North East Child FIRST intake system has opened an important alternative access point to services for very vulnerable families and strengthened community capacity to protect children outside of the tertiary child protection system (North East Metro Child and Family Services Alliance submission, p. 8).

This view is supported to some extent by preliminary trends in referrals to family services and Child FIRST. Figure 8.4 shows that since the introduction of Child FIRST in 2006-07, there has been a steady increase in referrals by child protection practitioners. There was also a consistent growth in referrals from schools and early childhood services to 2009-10. The trend for community and welfare services and related professionals and health services is more ambiguous, with increases in referrals of different proportions. There has also been a decline in self-referrals. This may suggest that family services have increasingly focused on high needs clients. The decline in referrals from all sources except child protection from 2009-10 to 2010-11, however, is of some concern. Given this mixed evidence, the Inquiry is unable to draw a firm conclusion regarding whether Child FIRST has created a more accessible entry point to family services.

Figure 8.4 Referrals to family services and Child FIRST, Victoria, 2005–06 to 2010–11

Source: Information provided by DHS

Service planning and coordination

Many participants to the Inquiry were of the view that Child FIRST has also supported coordination of different family services at the local level. The Joint CSO submission argued that a great strength of Child FIRST is its design and location – it is local, supports integrated responses and is multidisciplinary in its focus (p. 32).

Reinforcing the view of stakeholders, the KPMG evaluation found that the local Alliances have created: shared responsibility for service delivery to vulnerable children and families within local catchments; a mechanism to support consistent intake, prioritisation and allocation based on need and risk; an opportunity to consistently improve the service provision; capacity for joint planning; and a shared approach to demand management across family services (KPMG 2011b, p. 27).

KPMG also found, however, that not all Alliances had undertaken catchment planning, despite this being a core responsibility of Alliances. KPMG reported that some Alliances had not undertaken planning because they did not have sufficient resources, or they had been focused on 'more pressing' issues, such as maintaining relationships between CSOs to ensure the sustainability of the Alliance.

Where Alliances had completed catchment plans, there was considerable variation in the extent to which they included rigorous data analysis and identified the needs of local vulnerable children and families.

Collaboration with other services

In his 2009 investigation, the Victorian Ombudsman noted that the development of the Child FIRST system was a valuable step in encouraging a collaborative approach to protecting children while minimising the need for legal intervention (Victorian Ombudsman 2009, p. 65). Stakeholder submissions and Inquiry consultations have consistently identified the co-location of community-based child protection workers at Child FIRST sites as having had a positive influence on collaboration between family services and statutory child protection (submissions from Anglicare Victoria, p. 18; Bendigo Community Health Services, p. 10; Community and Public Sector Union, p. 11; MacKillop Family Services, p. 30).

In contrast, there remains a lack of coordination between family services and other services that focus on vulnerable children and young people. In some cases, this reflects a lack of basic awareness:

Last year the Office and Child Safety Commissioner engaged with staff working in adult drug and alcohol services at a series of forums and was surprised to hear that not many of those workers had heard of Child FIRST, let alone made a referral to them (Office of the Child Safety Commissioner submission, p. 6).

This suggests that the Children's Services Coordination Board (discussed in Chapter 20) has not been effective in coordinating government actions relating to children at local and regional levels.

The integration of family services with local adult and universal services is arguably a more ambitious objective than the initial aims of the Child FIRST program, however, addressing this issue may be a logical next step:

In hindsight, it would have been advantageous to formally include mental health and alcohol and drug services into the Child FIRST platform during the formulation of the CYF Act 2005. As it stands, responsibility for joint governance arrangements and local service integration including mechanisms for interagency consultation and support currently rests with funded family services. It would appear that responsibility to support family resilience and mitigate vulnerability and risk for children in a broad sense remains aspirational rather than actual. The need to build a platform where adult services are active and willing participants is the next step for a maturing Child FIRST system (Anglicare Victoria submission, p. 14).

Engagement with Aboriginal community controlled organisations

The Inquiry heard from some participants that the introduction of Child FIRST has assisted the integration of local ACCOs into the family services sector. KPMG found that partnerships between mainstream family services and ACCOs have generally improved at both the governance and service delivery levels.

From a governance perspective, ACCOs are now formally engaged as Alliance partners, and there is a stronger emphasis on mutual support. ACCOs gain through improving their understanding of mainstream programs that can be accessed by their clients, and having access to shared training and organisational support. For mainstream organisations, ACCO involvement enables improved cultural understanding, a more culturally competent approach, and the capacity to develop new service-delivery structures to better support Aboriginal children and their families. However, in some Alliances ACCO engagement continues to be limited by factors such as constraints on the capacity of the ACCO, or a limited focus on Aboriginal issues within the Alliance (KPMG 2011b, p. 42).

In some catchments this has impacted on service accessibility for Aboriginal children and families.

In terms of service delivery, mainstream agencies have sought to enhance the skills and cultural competence of their workforce, thereby offering greater choice in service providers to Aboriginal children and families (KPMG 2011b, p. xvii). In some catchments, the CSOs that form the Child FIRST Alliances funded an Aboriginal liaison position. These have played a significant role in providing culturally responsible services in some areas (VACCA submission, p. 41).

These gains have not, however, been realised in all areas of Victoria. KPMG found that within some Alliances, ACCO engagement is limited by ACCO capacity constraints, a limited focus on Aboriginal issues within the Alliance, or a lack of local ACCOs, which is reducing the extent of local knowledge available to Alliances (KPMG 2011b, p. 29). To build on the gains achieved elsewhere, there is a need for some mainstream agencies to focus on their relationships with ACCOs and for examples of good practice to be shared.

Meeting client demand

There is evidence that demand for family services is exceeding the available supply. KPMG found that there are increasing demand pressures within some catchment areas that Child FIRST is unable to effectively meet (KPMG 2011a, p. 88). Several Alliance lead agencies – particularly those in growth corridors – have moved to restrict intake in peak periods, while others have introduced waiting lists, potentially undermining the intention of responding at the early stage of a problem (Office of the Child Safety Commissioner submission). Several stakeholders from within the service system told the Inquiry that the government's investment in Child FIRST has not been sufficient to fully deliver on its objectives. The Inquiry accepts that greater government investment is required to respond to client demand, and considers it unacceptable that lead agencies in some areas have not been able to accept referrals of families in need.

The Inquiry also heard that the legislative requirement to focus on the highly vulnerable has meant that Child FIRST and family services can only deal with urgent matters, and matters involving cumulative harm are not able to be prioritised (Berry Street submission, pp. 15, 26). Consequently, the intended emphasis on cumulative harm that was introduced with the 2005 legislation has not been realised. VACCA stated that its family service is rarely able to support families with relatively 'straightforward challenges' (VACCA submission, p. 36).

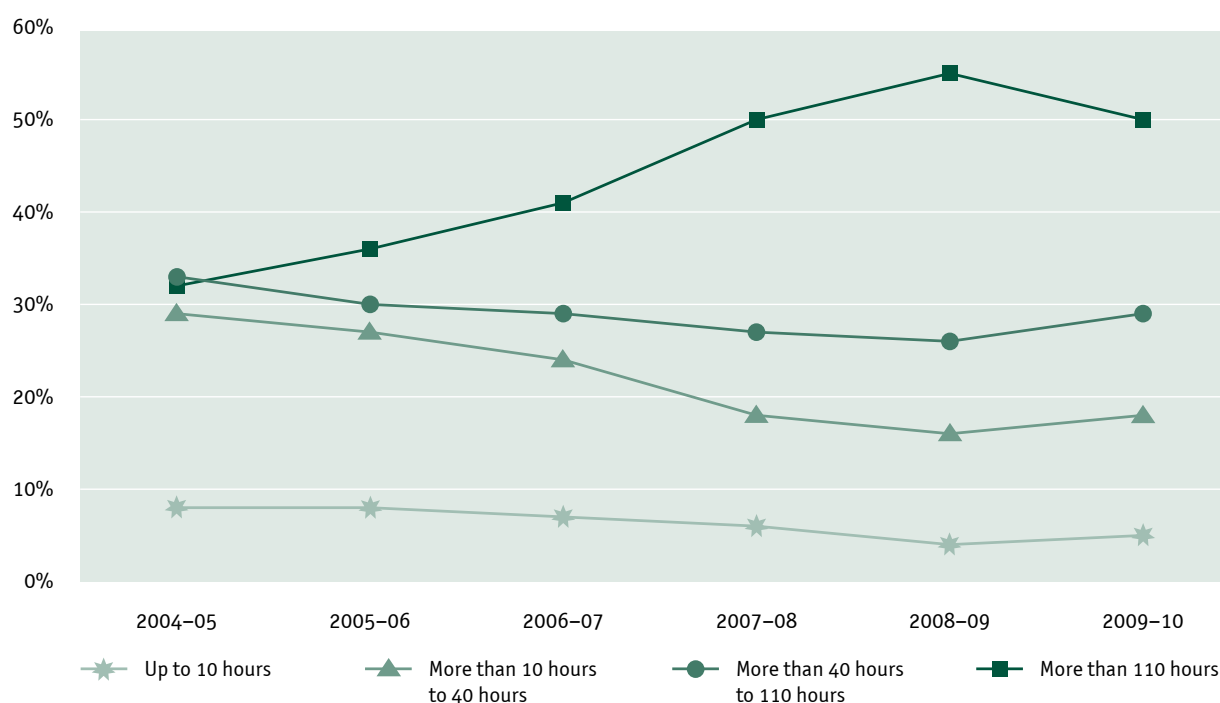
Information provided by DHS and many stakeholders suggests that demand pressures are being contributed to by an increasing number of families presenting to Child FIRST with complex and multiple issues. These issues can include a range of vulnerabilities and problems including: family violence; disability; debt and financial insecurity; parental stress; lack of social support and social isolation; mental health issues; and drug and alcohol problems (Anglicare Victoria submission, p. 12). In 2010, 92 per cent of all referrals to the North East Metro Child FIRST Alliance included one or more complex issues or significant wellbeing concerns (North East Metro Child and Family Services Alliance submission, p. 8).

The existence of increasingly complex cases for Child FIRST and family services is consistent with the data in Figure 8.5, which suggests that family services are working with fewer cases for longer periods of time. Recognising the increasing complexity of cases leads to consideration of whether the skills of the family services workforce are adequate to meet the needs of the presenting vulnerable children, young people and their families.

There is consistent criticism from CSOs that families that are at lower risk but that would benefit from supports are no longer meeting the threshold for access to family services because of the necessity to address the needs of the most vulnerable. This contention was supported by DOH, which suggested that health professionals are not making referrals to Child FIRST because families that had previously been referred had not met the threshold to receive services. It is also consistent with the KPMG finding that as family services increasingly manage more complex cases, their capacity to provide their former preventative intervention services is being reduced (KPMG 2011a, p. 4).

These criticisms need to be considered in the context that it was the intention of government when introducing reforms in the mid-2000s to ensure the needs of the highly vulnerable were prioritised. The combined effect of increased demand for family services, increased complexity of client needs, and the priority given to high-needs clients is that there appears to be a lack of capacity among family services agencies to work with a broader range of children and families.

Figure 8.5 Family services resources expended, by hours expended per case, Victoria, 2004-05 to 2009-10



Source: KPMG 2011b, p. 59

Role clarity

Related to the demand pressure facing family services, submissions and the Inquiry's consultations have highlighted that there is some confusion, misunderstanding or a 'gatekeeping' response regarding the boundaries between Child FIRST, family services and statutory child protection. A number of CSOs expressed the view to the Inquiry that statutory child protection was referring matters to Child FIRST that, in their view, required a statutory response. This issue is addressed further in Chapter 9.

As noted by the Victorian Ombudsman, it is inevitable that Child FIRST will have contact with children who should be referred to statutory child protection through protective intervention reports. In many ways Child FIRST is well placed to identify children at risk and ensure they are brought to the attention of DHS in a timely manner (Victorian Ombudsman 2009, p. 30).

There is a common contention that a high threshold for child protection services has resulted in higher risk cases being referred to Child FIRST from statutory child protection. Yet, there is little evidence available to the Inquiry to indicate the degree to which matters being referred by statutory child protection to Child FIRST are cases involving unacceptably high risk. It does seem that at times family services and statutory child protection may disagree as to the appropriate service response to some clients. The Inquiry considers that there is scope for the decision making regarding these clients to be more collaborative.

Early intervention

One of the key goals of Child FIRST and family services was to intervene earlier to assist vulnerable children and families, thereby avoiding the need for a statutory child protection response. Some stakeholders suggest that this goal has been achieved (Joint CSO submission, p. 31). The KPMG evaluation also supported this view, on the basis that statutory child protection reports, investigations and protective orders grew at a slower rate in Victoria compared with other jurisdictions between 2005-06 and 2008-09 (KPMG 2011a, pp. 127-128).

However, the Inquiry considers there is insufficient evidence to demonstrate that the introduction of Child FIRST has prevented some clients from being subject to a statutory child protection response. In particular, there is no evidence of a causal link between Child FIRST and any decrease in reports to statutory child protection. There are a number of other reforms and external factors that could have contributed to the change in the fall in reports. The Inquiry also notes that there was a substantial increase in reports to statutory child protection in Victoria in 2009-10 and 2010-11.

Client outcomes

There is a lack of evidence on the impact of Child FIRST and family services on outcomes for individual vulnerable children and their families. Further, there is little comment on this in submissions.

The Inquiry has been advised that work is underway within DHS to address this evidence gap. The Child and Family Services Outcomes Survey is a collaborative project to enable outcomes for a representative statewide sample of children receiving statutory child protection services, out-of-home care and family services to be measured and tracked over time. The first stage of the project surveys parents and carers about their children and focuses on their children's safety, stability and development including health, education, relationships and connections with family, community and culture. It will also include a range of questions about service experiences. It is intended that the survey will be conducted every two years. The second stage of the project, which will involve surveying children and young people, is due to commence in 2012.

While the initial findings from this work should be interpreted with caution, the preliminary report on the first survey includes a number of encouraging findings regarding family services, with parents and carers reporting they generally felt more confident in their parenting, were better able to relate to their children and manage their behaviour, as well as relate to others and manage their finances. About 75 per cent of parents believed that the child's health and wellbeing had improved since the provision of family services, and 90.4 per cent felt these improvements were as a result of the family service involvement. It is not possible to identify clearly whether family services had helped to prevent child abuse and neglect (Lonne et al. 2011).

The submission received from the North East Metro Child and Family Service Alliance (p. 9) provides some data regarding outcomes for children who have been engaged in Child FIRST and family services. The Alliance examined the outcomes for 382 families allocated to receive family services from Alliance agencies between July 2009 and June 2010, with follow-up occurring six months after allocation. The audit found that this Alliance of family services was generally effective at engaging complex, vulnerable families in services, with 67 per cent engaged, 13 per cent not engaged, and 20 per cent indeterminate.

It was further noted that the lowest engagement rate was with families referred from statutory child protection, with 58 per cent of referrals closed at Child FIRST. The study found that most referrals were closed because the families did not engage with services or ceased contact with services. This may suggest that Child FIRST is not as effective as an early intervention program if it is being provided to families that are not voluntarily engaged in working on problems within the family, and require an alternative tertiary response. While its conclusions cannot be generalised, this study demonstrates the benefits of analysing service data, and provides an example of how an audit or evaluation could be built into programs.

8.3.3 *Performance of specialist adult and youth services*

Victoria has a wide range of specialist adult and youth services including mental health services, drug and alcohol services, housing services and disability services. Many programs offered by specialist adult services to parents and caregivers are relevant to the risk factors for child abuse and neglect. Specialist adult services are therefore a critical platform for identifying vulnerable children and young people. In many instances, an adult service is also best placed to provide an early intervention service response to meet the needs of vulnerable children.

Family-sensitive practice

Family-sensitive policy and practice involves being aware of the impact of abuse upon families, addressing the needs of families and seeing the family – rather than an individual adult or child – as the unit of intervention (Battams et al. 2010).

Service providers owe a different duty of care to children. In order to respond effectively to the needs of children and young people, specialist adult services need to develop family-sensitive practices that incorporate risk assessment of child abuse and neglect, and the practical application of the service's responsibility to children.

The Inquiry received a number of submissions addressing family-sensitive practice. The Child Safety Commissioner suggested that developing a family focus in adult support services would enable better support to be provided to vulnerable children and families (Office of the Child Safety Commissioner submission, p. 6). The Family Alcohol and Drug Network noted that growing evidence indicates interventions that include family members are likely to achieve greater success than individually focused drug treatment programs (Family Alcohol and Drug Network submission, p. 2).

The College of Psychiatrists highlighted the potential benefit of strengthening priority access to mental health services for adults who are parents to vulnerable children. The college noted that under a narrow, adult-focused approach, some parents with a mental illness may not be able to access treatment due to the less severe nature of their illness. Under a broader, family-sensitive approach, some of those parents may receive treatment due to the impact of their illness on their parental functioning and as a consequence on the risk to the children (The Royal Australian and New Zealand College of Psychiatrists - Victorian Branch Faculty of Child and Adolescent Psychiatry and The Royal Australian and New Zealand College of Psychiatrists - Victorian Branch submission, p. 2).

The notion of supporting the needs of vulnerable children by prioritising the access to specialist adult services by parents and carers was canvassed in the recent New Zealand Green Paper for vulnerable children. The Green Paper suggested such a policy could apply to services where there are limited resources and adults may be on waiting lists, such as housing and alcohol and drug rehabilitation services. Some services use assessment tools that are too narrow to take the needs of vulnerable dependent children into account when determining their parents' or carers' priority for services (New Zealand Government 2011, p. 21).

In the United Kingdom a recent interim evaluation has considered the early stages of implementation of the *Think child, think parent, think family* guide being piloted by some service providers across adult mental health and children services to improve their response to parents with mental health problems and their families (Social Care Institute for Excellence 2011). While some preliminary promising practice is emerging, the evaluation highlights the significant challenges to this approach, particularly with competing pressures for service providers, the need for senior managers' commitment, information sharing challenges and the need for additional funding and resources to implement.

It is unclear to the Inquiry how extensive the adoption of family-sensitive practice and policy is in Victoria's specialist adult services. It is apparent, however, that services are not consistently identifying vulnerable children or delivering services that respond to their needs. While promising programs exist, they are varied, not coordinated, and without a simple, visible point of entry.

This gap is in part due to some confusion about who is responsible for the needs of vulnerable children and young people. Victoria lacks a clear expectation that specialist adult services must be responsive to the needs of their clients as parents and to the needs of their clients' children, even though their primary responsibility is to recognise the adult's personal needs and circumstances (Humphreys & Campbell (c) submission, p. 5).

Without an understanding of the extent of family-sensitive practice it is difficult, if not impossible, to determine how effective such a policy and practice would be in improving the role of specialist adult services in supporting early intervention to vulnerable children, young people and their families. An audit of all Victorian specialist adult services would assist in determining this matter.

The Inquiry is mindful that a broad adoption of family-sensitive practice by Victorian specialist adult services will have significant resource implications beyond increased service capacity. As noted by the Victorian Alcohol and Drug Association (VAADA), organisations will need to be redesigned to cater for a greater mix of clients, including children, which will require significant modifications to infrastructure. It will also necessitate the introduction of new training programs on models of service delivery and screening tools (VAADA submission, p. 7).

Service integration

Section 8.3.2 described the need for better links between family services and specialist adult services. The Inquiry also heard through submissions and consultations that an effective response to the multiple and complex problems for parents of vulnerable children and young people also required the integration of different specialist adult services. Odyssey House commented that the association between substance-dependence and family violence is of serious concern, not only between parents or adult partners, but also from parents to children and from adolescents and young adults towards parents. However, family violence is rarely identified or addressed within alcohol and drug services. The overlap in characteristics of families involved with child abuse and neglect, alcohol and other drug use, family violence and mental health suggests an urgent need to align the disparate services that address these parental factors with family services and the system for protecting vulnerable children more broadly. A shared framework, or universal screening tool, should be considered for all services working with vulnerable children and families (Odyssey House Victoria submission, p. 15).

Similarly, while a range of youth programs are available, they are not necessarily well connected with the broader service system supporting vulnerable young people, are not well coordinated with each other and may be difficult to access.

8.4 Conclusion

There is a great opportunity for the Victorian Government to provide earlier, more effective targeted supports for Victoria's vulnerable children and young people. The overseas evidence shows that early intervention programs, when well designed and resourced, can be an effective approach to improving a range of outcomes for vulnerable children and young people, including reducing the risk of child abuse and neglect. The long-term economic and social benefits of the most effective overseas programs far exceed their costs.

Victoria already has a substantial range of early intervention programs targeting vulnerable children and young people, but they do not come together to form a comprehensive, coherent and coordinated system of early interventions that addresses the needs of vulnerable children and their families. While service integration is improving, in the main, DHS, DEECD and DOH deliver or fund a set of early intervention programs to specific groups, consistent with their particular policy goals. There is an absence of holistic service planning and provision that meets the diverse needs of the particular child or young person and their family. This is an example of where the Children's Services Coordination Board, discussed in Chapter 20, has failed to drive coordination of government actions relating to children at local and regional levels.

In Chapter 6, the Inquiry recommends the development of a whole-of-government Vulnerable Children and Families Strategy to synchronise government efforts. The strategy would identify whole-of-government policy objectives, specific roles and responsibilities for individual departments, and a set of performance measures and indicators to monitor progress. As set out in Chapter 21, the Inquiry recommends that a new Commission for Children and Young People be established to oversee departments' performance in meeting their responsibilities under the framework.

An effective system of early intervention must both identify vulnerable children and families and deliver services that meet their needs. This requires all relevant services across sectors to put the consideration of the best interests of children at the heart of their practice. Universal services and specialist adult services have an essential role to play in the early identification of children and young people who are at risk and providing support based on a holistic assessment of the family's needs. Targeted services need to be coordinated at the local level to support an integrated, multidisciplinary response to individual families.

In Chapter 14 the Inquiry considers the role that amendments to legislation may provide to clarify the responsibilities of adult service providers to the children of their clients.

Enhancing early identification

The Inquiry recognises the potential benefit of utilising the CYF Act provisions regarding pre-birth reports to identify vulnerable children early and to avoid a tertiary response for these children. The Inquiry is also concerned, however, that there could be unintended consequences from subjecting a pregnant woman to the stress of a child protection pre-birth report, particularly if it is not followed by a comprehensive service response. The Inquiry therefore considers this to be an area that requires urgent evaluation.

Existing data systems and practices within services do not allow Victoria to identify all vulnerable children and young people who could benefit from early intervention services. There is a need for investment in modern client information systems that collect data about Victoria's children and their service utilisation. Improved data collection will support government agencies and services to better understand children's needs, improve the targeting of programs for vulnerable children, help maintain contact with hard-to-reach families, improve pathways between universal and targeted services, and support better program evaluation. As discussed in Chapter 20, it is important that appropriate protocols are established for the sharing of information without breaching clients' privacy.

Identifying vulnerable children and young people should be part of the core business of all universal early childhood services, schools, health services and specialist adult services. This chapter has identified promising practices in each of these sectors, but they are varied, not coordinated and not consistently adopted. The Inquiry recommends additional investment in these services supporting them to identify and respond to risk factors for child abuse and neglect and, where appropriate, to refer vulnerable families to other support services. Specialist adult services and health services should be supported to develop family-sensitive practices that address the needs of the whole family. A substantial increase in investment in DOH's Vulnerable Children's Program is required.

Through these steps, Victoria can make best use of its available resources to properly identify the families that would benefit from the support of early intervention.

Recommendation 15

The Government should enhance its capacity to identify and respond to vulnerable children and young people by:

- Evaluating the outcomes of pre-birth reports to statutory child protection and pre-birth responses to support pregnant women;
- Providing funding to support universal early childhood services, schools, health services (including General Practitioners) and specialist adult services to identify and respond to the full range of risk factors for child abuse and neglect. This should include increased investment in the Department of Health's Vulnerable Children's Program; and
- Providing funding to support specialist adult services to develop family-sensitive practices, commencing with an audit of practices by specialist adult services that identify and respond to the needs of any children of parents being treated, prioritising drug and alcohol services.

An integrated, comprehensive service response

The Inquiry has recommended that an area-based approach should be taken to address vulnerability and protect Victoria's vulnerable children and young people (see Recommendation 3 in Chapter 6).

Child FIRST and the local Alliances of family services provide a basis for developing an accessible entry point within a local catchment to a coordinated network of targeted services to meet the needs of vulnerable children and their families. However, the capacity of Alliances to deliver services that meet local needs is being undermined in several catchments because Alliances are not meeting their core responsibility to undertake service planning.

The Inquiry considers that the first step to reform family services should be to establish consistent governance arrangements across catchments to strengthen Alliances' accountability for their performance (Stage 1 of Figure 86). Area Reference Committees should be established in each catchment to oversee the monitoring, planning and coordination of services and management of operational issues. The Committees would comprise a representative of each CSO in the local Alliance, and be co-chaired by the DHS area manager and the chief executive officer or area manager of the lead CSO, ensuring that both DHS and the lead CSO are accountable for the Alliance meeting its responsibilities. The Inquiry anticipates that DHS will need to support some Alliances to develop the capacity to use data to inform service planning.

Accountability arrangements for Child FIRST should be strengthened further by ensuring that DHS' funding agreements with Alliance lead agencies clearly specify the CSO's role, accountability and responsibilities, and include appropriate performance measures. This would allow DHS to hold lead CSOs to account should they fail to meet their responsibilities.

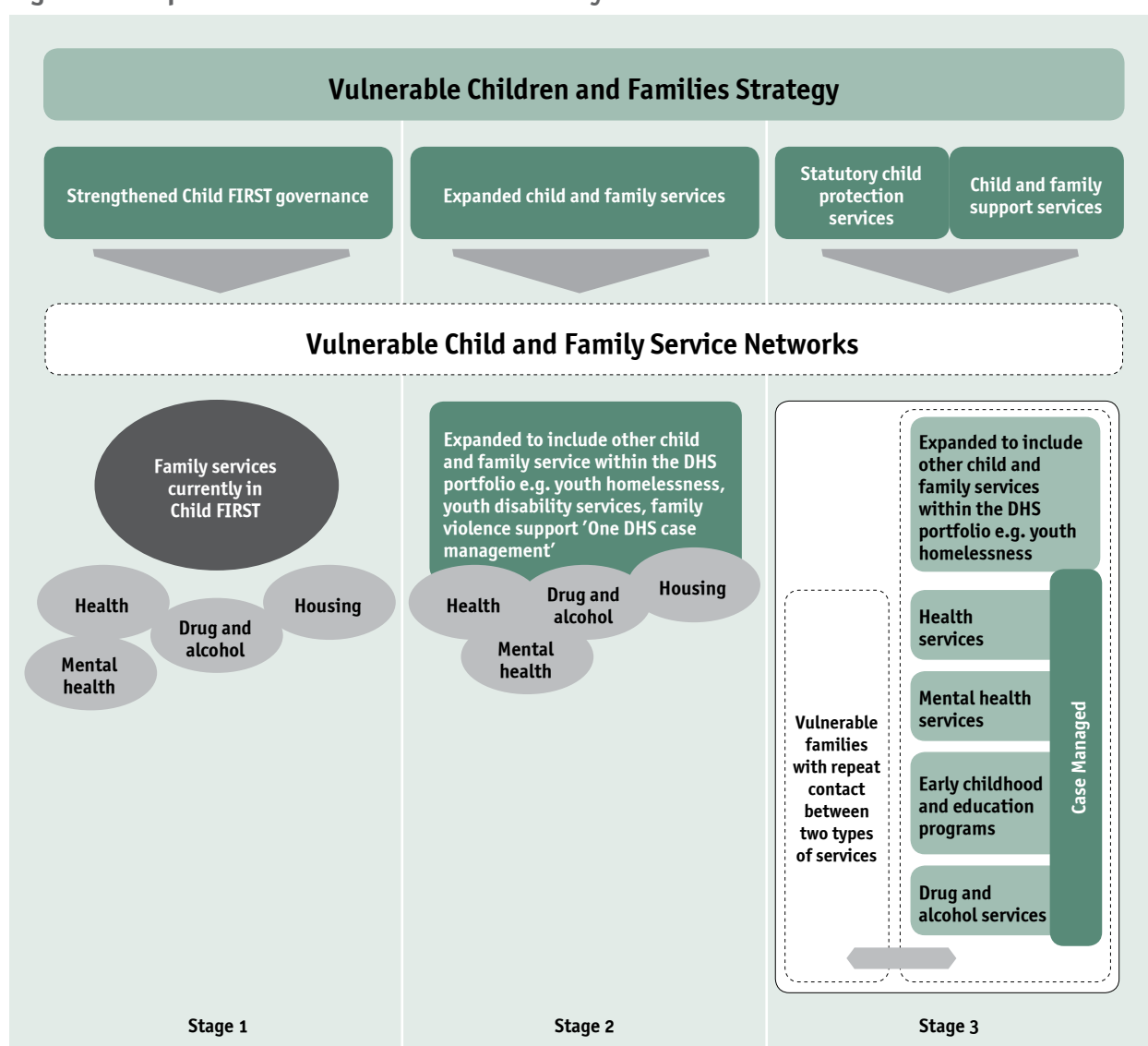
The Inquiry considers there is an opportunity to expand upon the existing Alliances of family services and statutory child protection services to develop broader, more coherent Vulnerable Child and Family Service Networks encompassing specialist adult services, health services and targeted programs linked to universal services. This would support the provision of an integrated package of services that meet the full range of needs of vulnerable children and their families. The networks should be expanded in stages, with the priority to be to include other services within

the DHS portfolio plus specialist adult services that address key risk factors of child vulnerability, such as drug and alcohol services and mental health services (Stage 2 of Figure 8.6).

This reform is aligned with the recommendation in Chapter 9 for the introduction over time of a consolidated intake model where Child FIRST and statutory child protection intake and referral processes are first co-located and then, potentially, combined (Stage 3 of Figure 8.6).

The consolidated intake and referral services would refer vulnerable children and families to the Vulnerable Child and Family Service Networks. Families would only need to enter the service system once, and the intake and referral service would be responsible for ensuring families receive an integrated, comprehensive service response. Families would no longer have to navigate a complex and uncoordinated service system themselves.

Figure 8.6 Expanded Vulnerable Child and Family Service Networks



Source Inquiry analysis

Consistent with the broadening of the Vulnerable Child and Family Service Networks, the Inquiry recommends that the legislative requirement to act in the best interests of children (which currently applies to family services under the CYF Act) be broadened to apply to all network services. As further recognition of our responsibility to vulnerable children and young people, legislation could also require services – particularly specialist adult services – to prioritise service delivery to vulnerable children, young people and their families. These provisions should be placed in the relevant legislation governing the services.

Recommendation 16

As part of a strategy to improve services for vulnerable children and families in need, the Department of Human Services should strengthen area-based planning and coordination of family services and accountability arrangements under Child FIRST by:

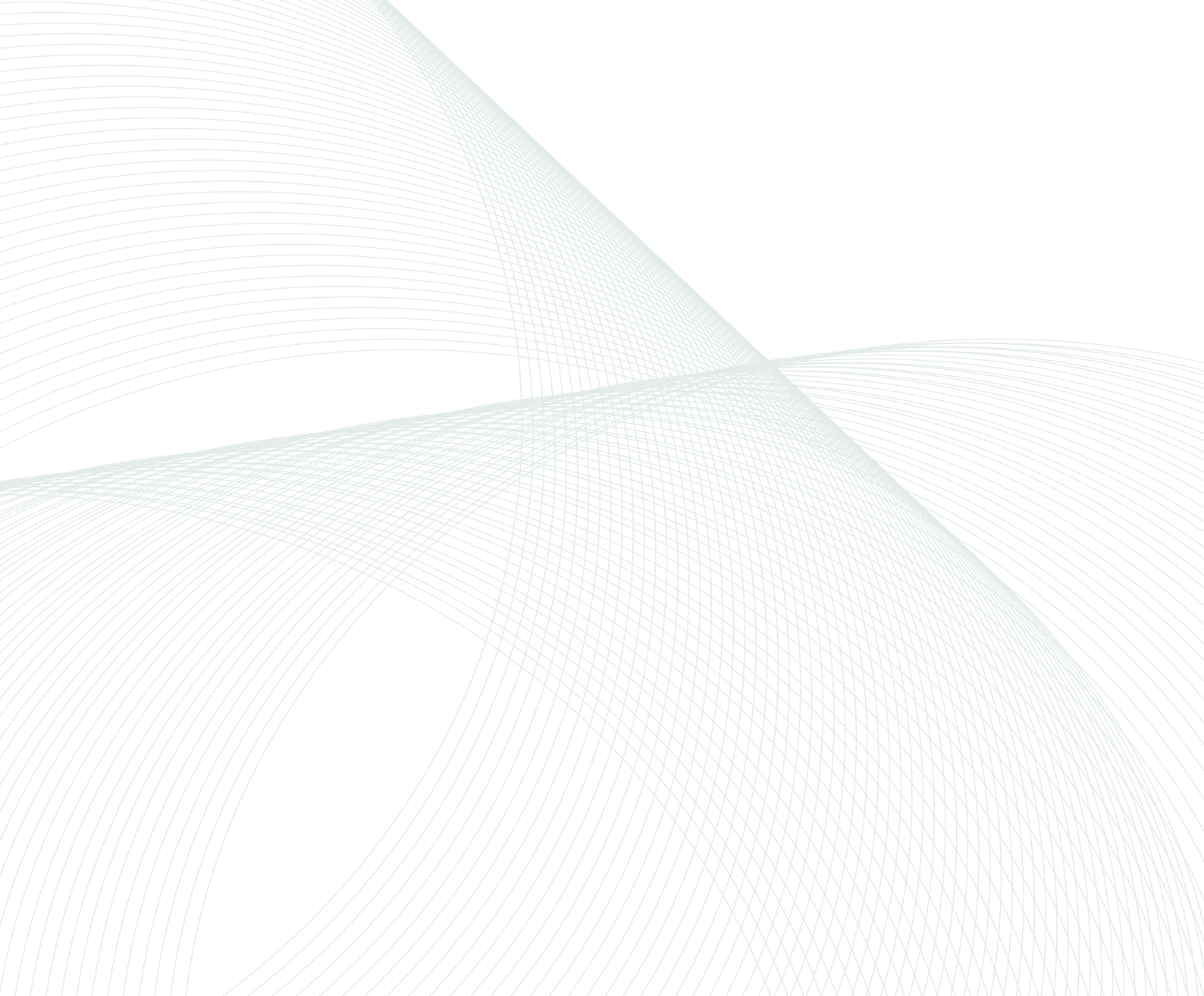
- Establishing Area Reference Committees to oversee the monitoring, planning and coordination of services and management of operational issues within each catchment. The Committees would be co-chaired by the Department of Human Services area manager and the chief executive officer or area manager of the lead community service organisation, and comprise a representative of each community service organisation in the local Alliance; and
- Ensuring the funding arrangements for Alliance lead agencies clearly specify the agencies' responsibilities for receiving referrals, undertaking an initial assessment of clients' needs, and facilitating an appropriate service response, with appropriate performance indicators.

Recommendation 17

The Government should expand upon the existing local Alliances of family services and statutory child protection services to develop broader Vulnerable Child and Family Service Networks – catchment-based networks of services for vulnerable children and families, including statutory child protection, family services, specialist adult services, health services and enhanced universal services.

Recommendation 18

The Government should ensure the legislation governing relevant services establishes the responsibilities of services to act in the best interests of children and young people, and to prioritise service delivery to vulnerable children, young people and their families. In addition, health services and specialist adult services should be required to adopt family-sensitive practice guidelines.



Part 4: Major protective system elements

Chapter 9:

Meeting the needs of children and young people
in the statutory system

Chapter 9: Meeting the needs of children and young people in the statutory system

Key points

- The Inquiry has investigated the quality, structure, role and functioning of statutory child protection services provided by the Department of Human Services (DHS).
- Submissions to the Inquiry raised a number of issues about statutory child protection services. DHS receives a large number of reports made by people about risks to the wellbeing or safety of children or young people. During 2010-11, there were 55,000 reports received and this rate is expected to grow further in future.
- The increase in the number of child protection reports is not a direct representation of the increase in prevalence of child abuse or neglect because reports today cover a much broader range of child and family welfare and safety issues than they did previously (for example, a child witnessing family violence). The expanded scope of reports reflects society's broadened understanding of vulnerability and what places a child at risk of harm.
- Evidence on outcomes for children receiving statutory child protection services indicates they will continue to have repeated contact with the Department of Human Services over the course of their lives, with multiple occurrences of harm or neglect. It is hard to see how such intervention is the most effective government response to ensure a vulnerable child's wellbeing and eventual transition to independent adult life.
- Statutory child protection services are likely to be most effective when they are balanced with other service responses designed to reduce vulnerability in the Victorian community.
- Statutory child protection services are resource constrained. The Department of Human Services needs to improve data collection on case complexity and other capacity constraints to inform future capacity analysis.
- Changes to the intake model are recommended to drive more effective decision making processes, reduce risk and to improve coordination of services to vulnerable children and their families. An area-based approach to co-located intake should be used (initially as a pilot) to bring the assessment of appropriate responses to wellbeing and protective intervention reports into more collaborative and coordinated arrangements.
- Once a child has been brought into the statutory system, DHS can improve the effectiveness of its services to improve outcomes for vulnerable children and families. The introduction of differentiated pathways will better recognise the vulnerability characteristics of children and their families requiring statutory intervention and allow service responses to be tailored accordingly.
- The Inquiry finds that it presently takes too long for a child in out-of-home care to achieve placement stability and this exposes too many children to additional trauma. Where appropriate, barriers to adoption and permanent care must be identified and removed.
- Recommendations to improve and simplify case planning and improve collaboration across service agencies are also made. Guidance and instructions for child protection practitioners should be simplified and DHS should continue to strengthen the information technology systems required to support practice.

9.1 Introduction

The Inquiry's Terms of Reference includes the quality, structure, role and functioning of statutory child protection services. Specifically, the Inquiry was asked to examine reporting, assessment and investigation procedures as well as responses to child abuse and neglect.

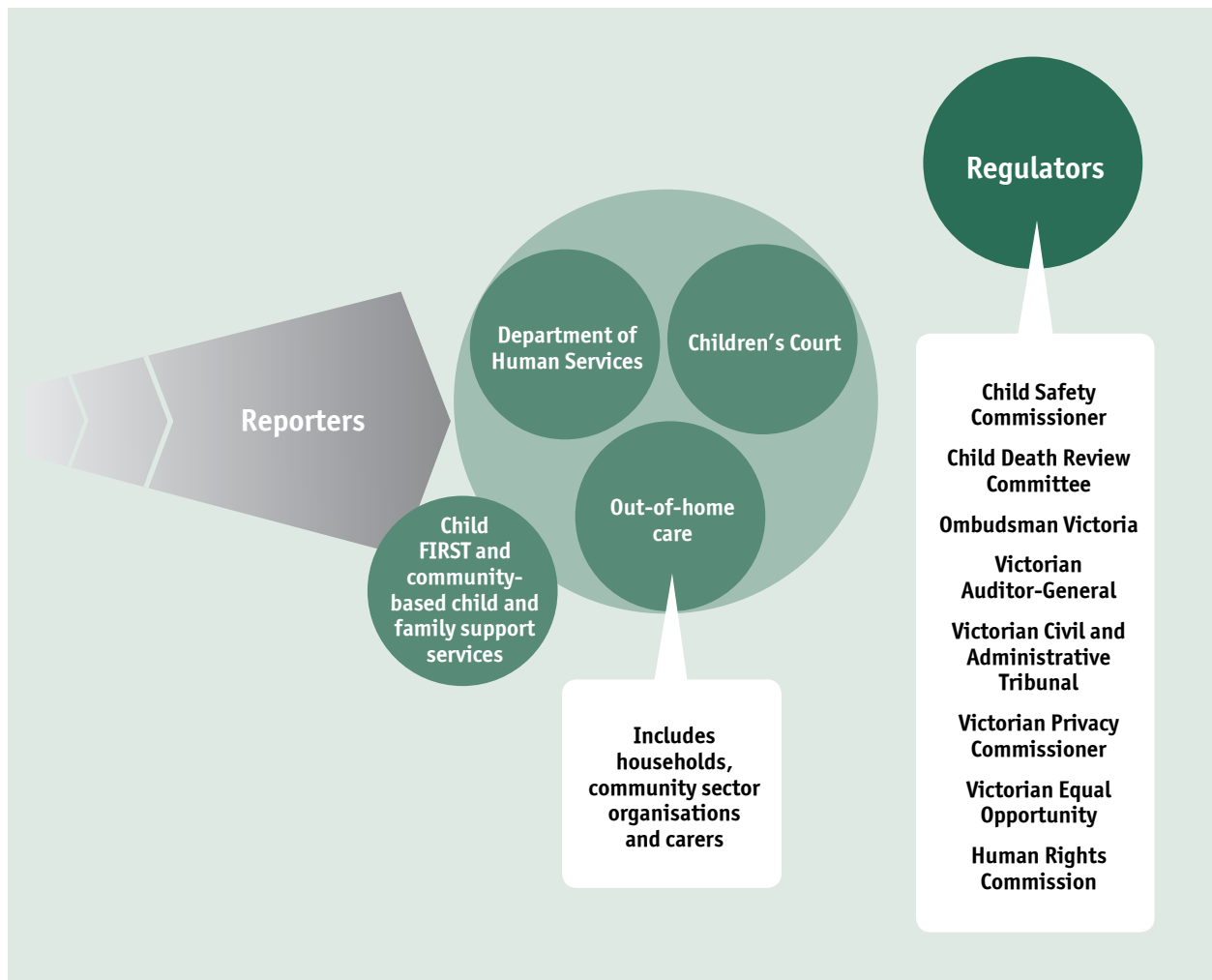
Statutory child protection services are provided by the Department of Human Services (DHS) and they involve:

- Investigating matters where a person has raised concerns about a child's safety or wellbeing (known as a 'report');
- Referring children and families to voluntary support services to assist a family to provide for the ongoing safety and wellbeing of their children;

- Using statutory powers and seeking orders from the Children's Court to take action if a child's safety within their family is at risk, including placing a child in alternative care arrangements or supervising a child in their home;
- Supervising children on orders granted by the Children's Court; and
- Providing and funding out-of-home care accommodation services, specialist support services, and adoption and permanent care to children and adolescents in need (DHS 2011a).

Figure 9.1 illustrates the context in which these activities take place within Victoria's system for protecting children.

Figure 9.1 Victoria's child protection system: principal parties and scope



Source: Inquiry analysis

This chapter examines Victoria's statutory child protection services and proposes six recommendations. The chapter is organised as follows:

- First, a brief description is given of the legislative and services framework and the five main phases of statutory services. These phases are: intake, investigation, protective intervention and assessment, protection order and case closure.
- Second, the chapter describes trends and other metrics to provide a sense of the scale, dimensions and patterns of statutory child protection services provided by DHS.
- Third, the chapter addresses the current performance of statutory child protection services by presenting available data on benchmarks and standards, recent Victorian Ombudsman reports and child death reviews.
- Fourth, using the material and input received through submissions to the Inquiry, three major issues are canvassed; these are:
 - the question of whether statutory child protection services are sufficiently resourced to intervene when required to protect vulnerable children and young people;
 - the efficiency and effectiveness of child protection practice; and
 - the need to improve stability in placements for vulnerable children and young people to avoid causing them further harm and trauma.
- Finally, recommendations are made that address these key issues.

As part of statutory services, DHS applies for a variety of legal orders through the Children's Court to authorise some types of interventions for protecting children and young people. The role and operation of the Children's Court in granting different types of legal orders is examined in detail in Chapter 15, along with proposed recommendations to simplify these processes.

9.2 Current legislative and service framework

In relation to statutory child protection services, the Secretary of DHS holds overarching responsibilities under the *Children Youth and Families Act 2005* (CYF Act) (section 16), these are:

- Promoting the prevention of child abuse and neglect;
- Assisting children who have suffered abuse and neglect and providing services to their families to prevent further abuse and neglect from occurring;
- Working with community services to promote common policies on risk and need assessment for vulnerable children and families;
- Implementing appropriate requirements for checks ensuring that those working with children are suitable and comply with appropriate ethical and professional standards;
- Working with other government agencies and community services to ensure children in out-of-home care receive appropriate educational, health and social opportunities;
- Conducting research on child development, abuse and neglect and evaluating the effectiveness of community-based and protective interventions in protecting children from harm, protecting their rights and promoting their development;
- Leading the ongoing development of an integrated child and family service system; and
- Giving effect to protocols existing with Aboriginal agencies.

The Secretary also holds a number of responsibilities relating to the provision of out-of-home care services, including:

- Publishing and promoting a charter for children in out-of-home care; and
- Providing and arranging for services supporting transition from out-of-home care to independent living.

DHS delivers child protection statutory services through a case management approach for each child or young person. The delivery of statutory child protection services is structured into five phases: intake, investigation, protective intervention and assessment protection order and case closure. An overview of these phases is provided in Figure 9.2 (see Appendix 9 for a detailed description).

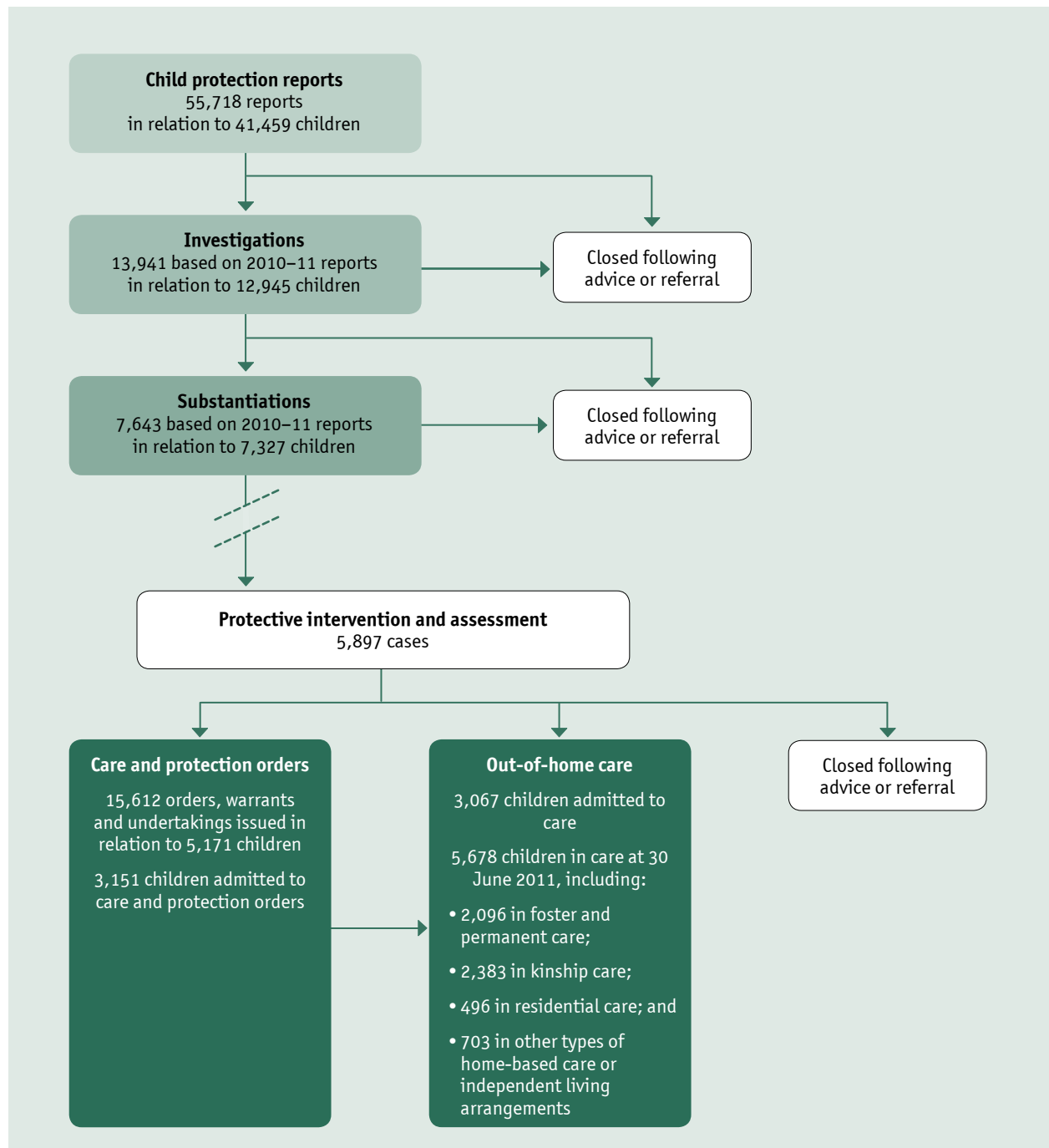
The activities that take place in each phase are described from section 9.2.1 onwards.

DHS employs about 1,200 child protection practitioners and service delivery is structured through eight regional areas across Victoria (information provided by DHS).

Child protection practitioners are supported in their work by their supervisors, managers and materials such as the *Child Protection Practice Manual* (DHS 2011k). The practice manual covers a wide range of operational issues including confidentiality, supervision, procedures to be adopted for children in specific circumstances, critical incidents and complaints management to name a few.

Specific workforce issues including capability and a sector-wide approach to professional development are canvassed in detail in Chapter 16. Chapter 21 will examine the governance arrangements and oversight mechanisms for statutory child protection services.

Figure 9.2 Overview of activity in Victoria's statutory child protection system, 2010-11



Source: Information provided by DHS

Note: Figure shows child protection reports for 2010-11 and investigations and substantiations relating to those reports. For protective intervention and assessment, care and protection orders and out-of-home care, the figures shown detail the level of activity for 2010-11 (unless otherwise stated), including activity relating to child protection reports received prior to 2010-11. The term 'substantive orders' is synonymous with the Australian Institute of Health and Welfare's (AIHW) 'care and protection orders' so these are not indicated separately.

9.2.1 Phase 1: intake

The intake phase is where a family becomes involved with statutory child protection because concerns are raised about the health and wellbeing of their children.

A summary of the objectives of intake services are to:

- Identify and prioritise Victorian children and young people who require statutory investigation because they are at high risk of harm; and
- Provide links to family support services, so that vulnerable families are assisted when circumstances do not require statutory intervention.

Reports of concern

DHS becomes aware of concerns about a child's welfare when a report is made to them by an individual.

Reports are made either to DHS directly, or to Child FIRST (see Figure 9.3). When reports are made to Child FIRST, if the concerns are determined by Child FIRST and the community-based child protection practitioner to be of a serious nature, they are referred to DHS. The area within DHS that receives and makes decisions about reports is called child protection intake. In the past, reports were known as notifications.

Reports and related queries come from many different sources, including community members, relatives of children or young people, professionals who interact with them (for example, nurses or teachers), Centrelink officers, Family Court officers, and interstate and overseas statutory child protection authorities. Some individuals are required by law to make reports by virtue of their professional occupation and this mechanism is examined further in Chapter 14. Reports convey a wide range of concerns about a child or young person's wellbeing and the CYF Act specifies that there are two categories: wellbeing reports and protective intervention reports.

Two different categories of reports

A wellbeing report: where a person has significant concerns for the wellbeing of a child. These reports are directed to Child FIRST.

A protective intervention report: where a person believes, on reasonable grounds, that a child is in need of protection. These reports are directed to DHS statutory child protection intake.

The two types of reports described above reflect different levels of perceived risk surrounding a child or young person's safety. A protective intervention report involves the highest severity of risk. In line with the principle of protecting the family as a core unit of society, Victorian statutory child protection services must only intervene where there is an unacceptable risk of harm or neglect because a family is unable to provide adequate care and protection for their child.

Once a report is received, DHS child protection practitioners assess the individual circumstances and risks and make a decision about what course of action should be taken. Once it has been determined that a report is a protective intervention report, the matter moves to phase 2 and an investigation is conducted. If the report does not meet this threshold, a referral to child and family support services may be made instead of an investigation, for example, a child's family may be referred to a family violence, housing or mental health service provider. In order to do this, DHS either refers a reporter to the Child FIRST intake or directly to the relevant service provider.

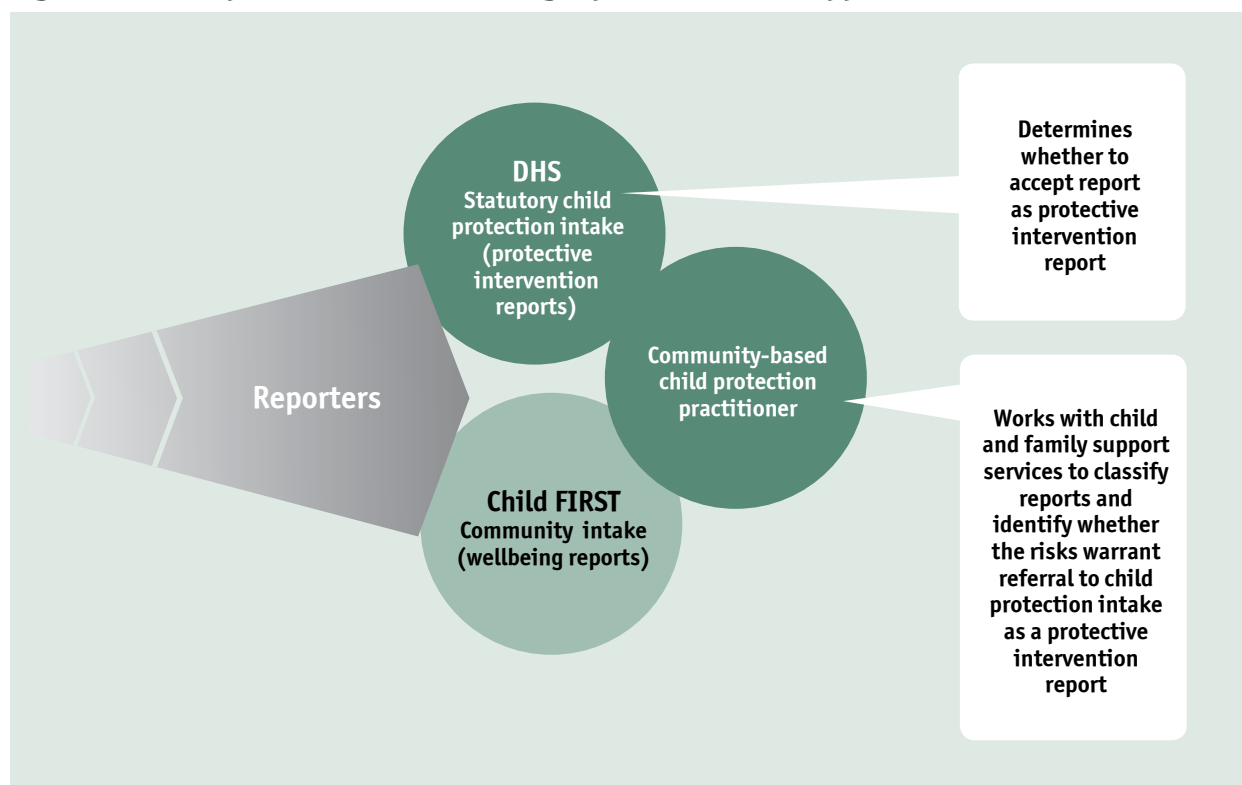
Another option for a child protection practitioner is to determine that no further action should be taken in relation to a report. If this is the case, then the matter will be closed. Cases may be closed at any point throughout the phases of statutory child protection services, if it is determined by DHS that statutory intervention is no longer required.

There are often grey areas concerning reports; sometimes it is not clear whether a report about the circumstances of a child has met the threshold required to trigger a statutory investigation. Some reports allege serious abuse or harm and require urgent action by statutory child protection practitioners. For example, a hospital emergency department professional may report that a child's fractures are non-accidental and there is a serious likelihood that they were caused by the child's caregiver. Other reports are less clear-cut, covering issues such as a child's appearance and behaviour at school.

Grounds of harm

The grounds of harm in the CYF Act authorise statutory child protection intervention in a specific list of areas, including where a child's parents are dead or incapacitated, where a child is abandoned by their parents, or where a child is, or is likely to, suffer significant harm as a result of their parents' actions (or inability to protect them from another's actions). In 2005 the areas of harm were broadened to include when harm is caused by not only single acts, omissions or circumstances causing significant harm but also accumulated through a series of acts, omissions or circumstances (s. 162(2), CYF Act).

Figure 9.3 Child protection and wellbeing reports: Victoria's approach



Source: Inquiry analysis

9.2.2 Phase 2: investigation

A summary of the objectives of the investigation phase are to:

- Examine the circumstances of a protective intervention report and determine whether the claims of abuse or neglect are substantiated;
- Make a decision as to whether continuing statutory intervention is required to protect a vulnerable child or young person;
- Make decisions and arrangements in a way that incorporates the child's views (so long as they are of an appropriate age and stage to participate) and collaborate with relevant members of the child and family's network; and
- Work effectively with other professionals involved in providing care and services to the child and their family to enable a holistic and accurate assessment of harm or the risk of harm to a child.

To investigate a report, a team of two child protection practitioners directly contact the child or young person, their parents, professionals and significant others who are aware of the child and family in order to collect information about the situation. Generally, families are visited at home although sometimes children will be interviewed separately at different locations such as school.

The CYF Act requires this investigation to occur in a way that is in the best interests of the child (s. 205). Child protection intake is required to report to Victoria Police all allegations and situations of sexual abuse, physical abuse or serious neglect (DHS 2011k, advice no. 1184; protocol agreement with Victoria Police, see Chapter 14).

Generally, investigations rely on the voluntary participation of the family in allowing practitioners to visit their homes and meet with relevant caregivers. Investigations, however, produce information that may be used in future court proceedings, so child protection practitioners must warn the child and the child's parents that any information they give may be used for the purpose of bringing an application before the Children's Court (s. 205, CYF Act). If the family refuses to participate in an investigation, child protection practitioners must seek court authorisation to require information to be collected. After gathering and assessing available evidence, child protection practitioners must determine whether significant harm has occurred to a child, and whether their safety, stability and development is at further risk. One of the outcomes of an investigation is that DHS might seek orders to remove the child from the family and place them into alternative care. When a child protection practitioner finds that a child has suffered or is at risk of suffering significant harm, a protective intervention report is found to be substantiated.

Once substantiation decisions are made, the child protection practitioner then determines what type of further interventions are required to ensure the safety, stability and development of the child. The case may then proceed to the protective intervention phase or, alternatively, the family may be referred to family support services. In other cases, the child protection practitioner may provide advice to the family or take no further action. Advice provided to the family may cover matters such as the availability of family mediation for adolescents, Family Court custody or access matters, or even financial counselling services. No further action may be taken in cases where the report is substantiated, but the child is no longer deemed to be at risk of harm because the family circumstances may have changed. The case would then be closed.

As noted above, case closure can occur at any point across the phases if no grounds for continuing statutory intervention are present.

9.2.3 Phase 3: protective intervention and assessment

A summary of the objectives of the protective intervention phase are to:

- Ensure a child's immediate safety from harm or from an unacceptable risk of harm;
- Address the impact of the harm suffered to date by the child and work with the child's family to ensure that change occurs and the child's future needs are addressed;
- Make decisions and arrangements in a way that incorporates the child's views (so long as they are of an appropriate age and stage to participate) and collaborate with relevant members of the child and family's network;
- Plan and take actions to prevent the need for alternative care arrangements so the child can safely remain in their family home;
- Work effectively with other professionals involved in providing care and services to the child and their family to enable a holistic and accurate assessment of a child's needs and ensure their safety and wellbeing.

During the protective intervention and assessment phase, child protection practitioners must decide whether they require a court order to assist their work with a vulnerable family.

The activities in this phase involve DHS working with the family to address risks and other issues affecting a child's safety and wellbeing. Child protection statutory services must carry out these activities in concert with a range of other service providers.

Family group conferences and other types of meetings may be held where the child protection practitioner can discuss issues and next steps with a child's family. The child protection practitioner is continually assessing their view of the level of risk to a child and what type of assistance and support is required to enable a family to care for their child. Case planning supports a child protection practitioner's assessment work.

Case planning is also intended to address a child's stability needs. Stability includes a child's relationships with their primary carer, their friends, extended family and connections to kindergarten, school and other social or recreational activities.

Case plans produced during the protective intervention phase are to outline:

- Evidence of harm to the child and the risk of harm to the child's safety, stability and development (these concerns should be shared with the parents);
- Ongoing review and assessment processes for determining whether court involvement is required;
- Any additional assessments of the child or parents that are required to inform decision making;
- Immediate goals, actions and timelines to determine safety or parental capability to protect the child from harm and promote stability and healthy development; and
- How the family will be supported by statutory child protection services to implement the plan (DHS 2011k, advice no. 1282, p. 15).

As a result of assessment, a child's parents may be encouraged to participate in relevant support services and undergo monitoring, bearing in mind the consequences if they do not participate could be that DHS applies for court orders that require assessment, treatment, temporary care or other types of statutory interventions. Such activities help child protection practitioners assess a parent's willingness to change and improve the care of their children. For example, this might involve regular voluntary drug testing or parenting classes.

9.2.4 Phase 4: protection order

If a child protection practitioner determines that they are unable to work effectively with a vulnerable child or young person's family on a voluntary basis to ensure the child's safety, they will make a protection application to the Children's Court. Child protection practitioners will seek one of a variety of orders to obtain lawful authority to mandatorily intervene in the child's family, for example, to further supervise or monitor a family, or potentially, to make alternative arrangements for the child's care.

The objectives of the protection order phase are much the same as for the protective intervention and assessment phase (see section 9.2.3). The key element of the protection order phase is that it provides a child protection practitioner with specific lawful authority arising from a protection order. The type of order obtained will determine the nature and duration of the mandatory intervention into a vulnerable child's life.

Additional case management activities carried out by child protection practitioners during the protection order phase could include:

- Monitoring compliance with court orders and conditions, for example, receiving results of drug screening of parents or seeking warrants when children are missing or abducted;
- Making decisions on placement options when it has been determined a child should be placed in out-of-home care, reunification with parents or permanency planning; and
- Making decisions about closing the case, when child protection cease to be involved with a child or young person, for example, when a child is transitioned to independent living at 18 years of age.

Case plans after a protection order is made

Within six weeks of obtaining a court order, a formal case plan must be prepared by a child protection practitioner (s. 167, CYF Act). Case plans should document all significant decisions made by DHS about the present and future care and wellbeing of the child, including the placement of and access to the child (s. 166, CYF Act).

The practice manual provides that children should be invited to participate directly in planning meetings and assisted to understand the importance of their role in the process.

Several different types of plans are completed by child protection practitioners, including:

- Protection order case plans (also referred to as 'best interests' case plans) – these are overall plans for children made after a court order has been issued (s. 166-7, CYF Act);
- Cultural plans for Aboriginal children and Torres Strait Islander children (s. 176, CYF Act);
- Case and care management or placement plans – for children in out-of-home care covering a child's needs, planned outcomes, roles and responsibilities of carers and parents (DHS 2011k, advice no. 1284, 1282);
- Stability plans – prepared for children placed in out-of-home care (s. 170, CYF Act);
- Education support plans – prepared for children placed in out-of-home care (DHS 2011k, advice no. 1284); and

- Leaving care plans (DHS 2011k, advice no. 1418).

Protection order case plans cover a variety of matters including:

- Goals addressing the child's stability and development needs;
- Stability plans – covering proposed long-term carers for a child;
- Arrangements and strategies addressing the child's developmental, educational and health needs, including dealing with therapeutic treatment;
- Cultural support matters;
- Conditions stipulated in the protection order, for example, the amount of access between a parent and their child or, if the child remains at home, the amount of access for child protection practitioners to monitor and assess the child;
- Tasks and timelines for actions and next steps; and
- Contingency arrangements to apply if the plan is not working.

Protection order case plans will vary due to the variety and breadth of types of cases and individual circumstances of each vulnerable child and family. Protection order case planning is undertaken by unit managers, who are more senior, experienced child protection practitioners.

Although a child's stability needs informs case planning and out-of-home care decisions, once a child has been placed in out-of-home care, a formal stability plan is required. Formal stability plans must be prepared within certain timeframes that depend on the child's age, and the duration and length of time spent in out-of-home care (s. 170(3), CYF Act).

Reunification planning

Reunification planning is triggered when a child has been placed in alternative care. Reunification is the primary goal of statutory child protection intervention where it is in a child's best interests, as this aligns to society's fundamental expectation that the family be protected as a core unit of society. Further, the bond between a parent and child should be preserved as much as possible (s. 10(3)(a), CYF Act).

Reunification is intended to be a planned and timely process for safely returning a child to their home and facilitating their future safety and wellbeing in that home.

Once a decision is made about the alternative care arrangements required, DHS contracts with community service organisations (CSOs) to provide placement and care services for individual children. Out-of-home care is discussed in further detail in Chapter 10.

9.2.5 Phase 5: case closure

At each of the previous four phases, cases are closed when a decision is made that statutory intervention is not warranted.

Activities carried out when closing a statutory child protection case involve:

- Finalising steps taken to protect the vulnerable child, promote their healthy development and support the family (this could be through planning processes);
- Complete casework actions and tasks to discharge DHS' duty of care and other responsibilities to the child and the family and also to reliably inform possible future case management; and
- Ending DHS statutory child services involvement and intervention with a vulnerable child and their family.

9.3 The statistical dimensions of statutory child protection services

This section provides an overview of the scale, dimensions and trends of statutory child protection activities. Information presented is drawn from a range of published and unpublished sources, including:

- The Steering Committee for the Review of Government Service Provision (SCRGSP) *Report on Government Services 2011*, which contains time series

and inter-jurisdictional data up to the 2009-10 financial year;

- A range of unpublished data provided to the Inquiry by DHS, including key statutory system metrics for the 2010-11 financial year; and
- The Inquiry's own analysis of de-identified unit records, provided by DHS, for all children who were the subject of a child protection report to DHS in 2009-10.

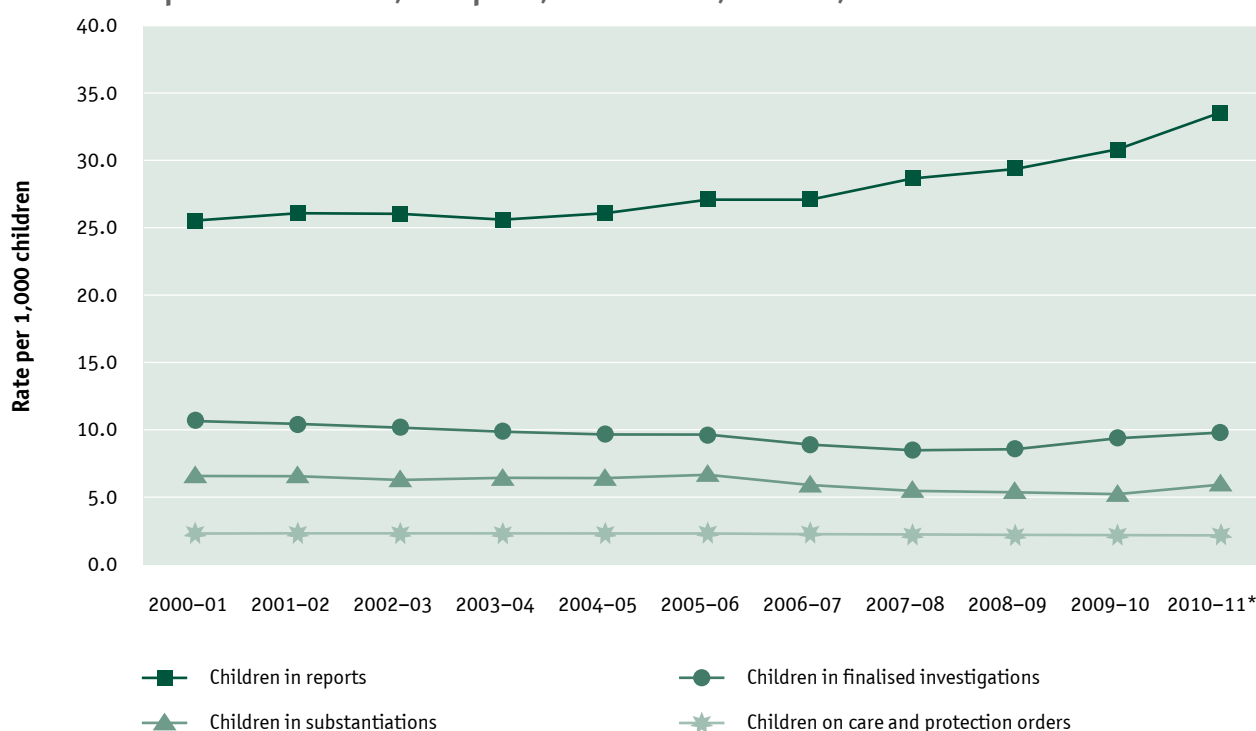
The Inquiry has sought to use the most up-to-date information available. However, as noted above, this includes a combination of 2009-10 and 2010-11 data.

As well as details about the statutory services provided, this section presents information on the typical characteristics of children interacting with the statutory child protection system, regional variations in child protection activity and overarching trends.

Context: trends over time

As was outlined in Chapter 2, reporting trends over time show an increasing rise in the numbers of protective intervention reports made about children and young people. Figure 9.4 provides a historical view of not only reporting trends but also investigations and substantiation trends over time for and children admitted to care and protection orders in Victoria.

Figure 9.4 Child protection reports, investigations and substantiations and children admitted to care and protection orders, rate per 1,000 children, Victoria, 2000-01 to 2010-11



Source: SCRGSP 2011c, Table 15A.53

* Provided to the Inquiry by DHS

Although reports have increased over time, substantiations have remained relatively constant and there has not been a corresponding growth in investigations.

During 2010-11 the DHS statutory child protection service received 55,718 child protection reports. These reports resulted in just under 14,000 investigations, or just under one investigation for every three reports. Of the reports that were investigated, just over half resulted in DHS substantiating that the child has been harmed.

In the majority of cases where substantiations of harm were found, the case proceeded to the protective intervention and assessment phase where a range of interventions may occur. In 2010-11, there were 3,151 children admitted to care and protection orders, including supervision, custody, guardianship or permanent care orders. During 2010-11, 3,067 children were admitted to out-of-home care.

9.3.1 Child protection reports

The Inquiry was provided with de-identified unit records for all children who were the subject of a child protection report to DHS in 2009-10. There were just over 48,000 received in 2009-10 compared with 55,718 in 2010-11. These records show that it is not uncommon for children to be the subject of multiple reports during a single year. The 48,000 reports received in 2009-10 relate to some 37,500 children. Figure 9.5 shows the age and sex of these children.

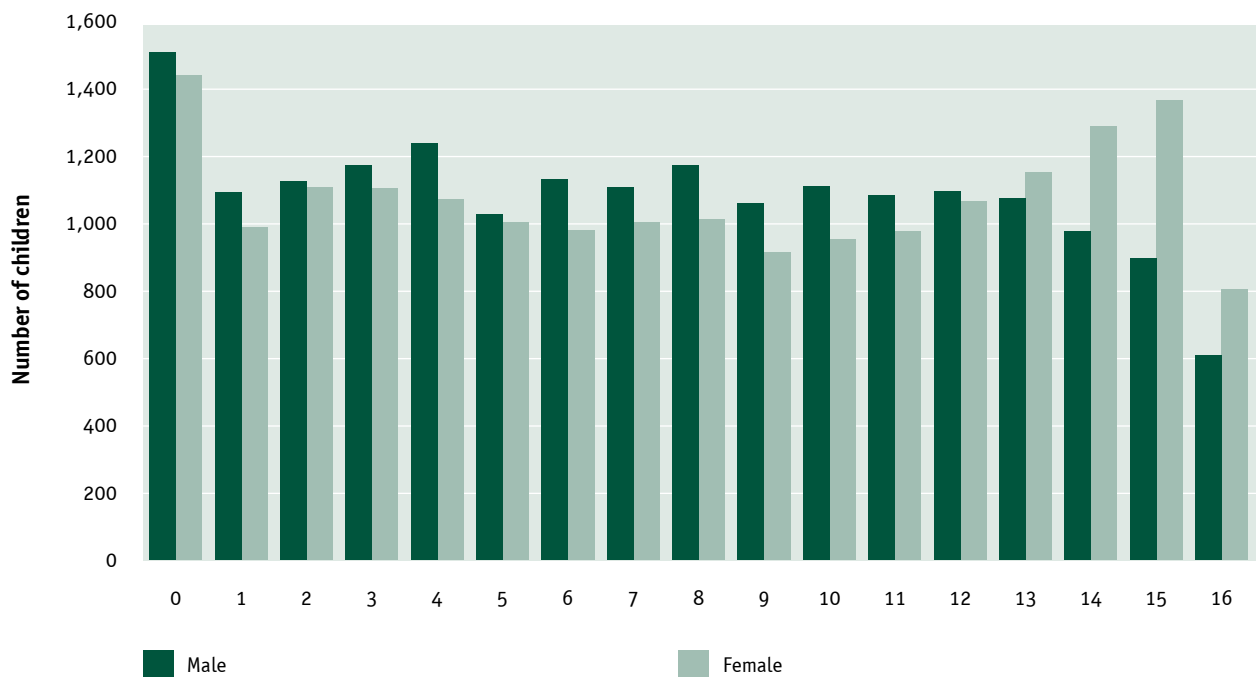
Characteristics of reports

There were more reports received about children aged under one than other ages in 2009-10 (see Figure 9.6). While boys aged under 13 were slightly more likely to be the subject of a report than girls of the same age, girls were more likely to be the subject of a report for ages 13 and over.

The largest number of reports were received by the three metropolitan DHS regions, with the majority of these reports received by the North and West Metropolitan and Southern Metropolitan regions (see Figure 9.7). Regional differences in reporting patterns were discussed as part of the incidence of vulnerability across Victoria in Chapter 2.

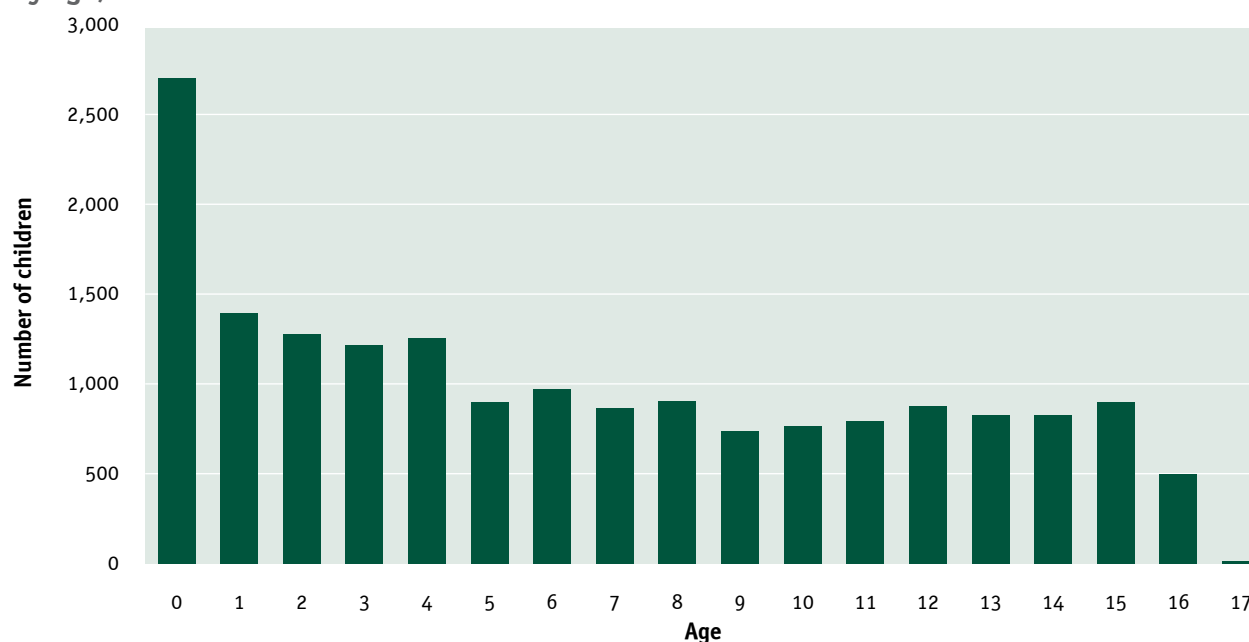
Even though the three metropolitan DHS regions received the highest number of reports in 2009-10, on a per capita basis, rural regions (with the exception of Barwon-South Western) received more reports, with Gippsland and Loddon Mallee regions receiving the highest number per capita (see Figure 9.8).

Figure 9.5 Children who were the subject of a child protection report, by age and gender, Victoria, 2009-10



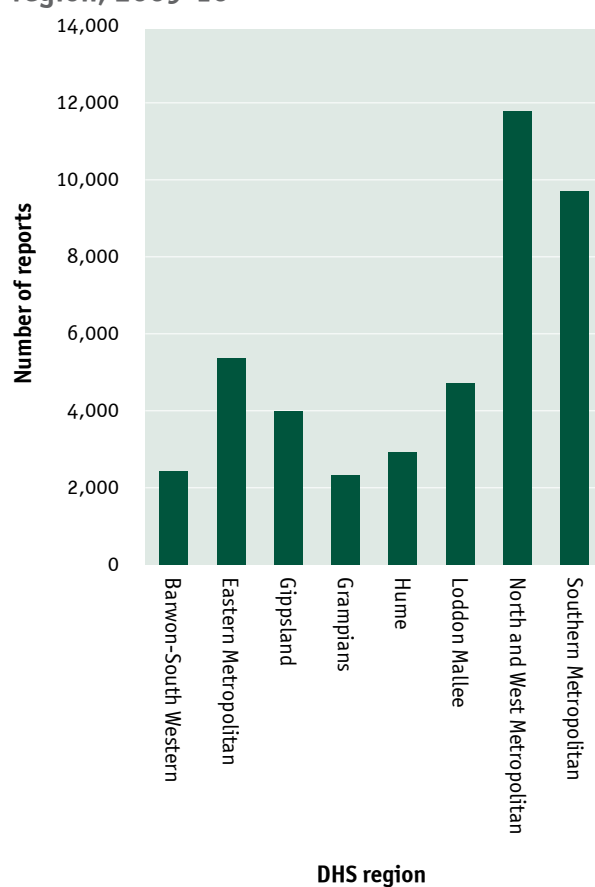
Source: Inquiry analysis of information provided by DHS

Figure 9.6 Children who were the subject of their first child protection report in 2009-10, by age, Victoria



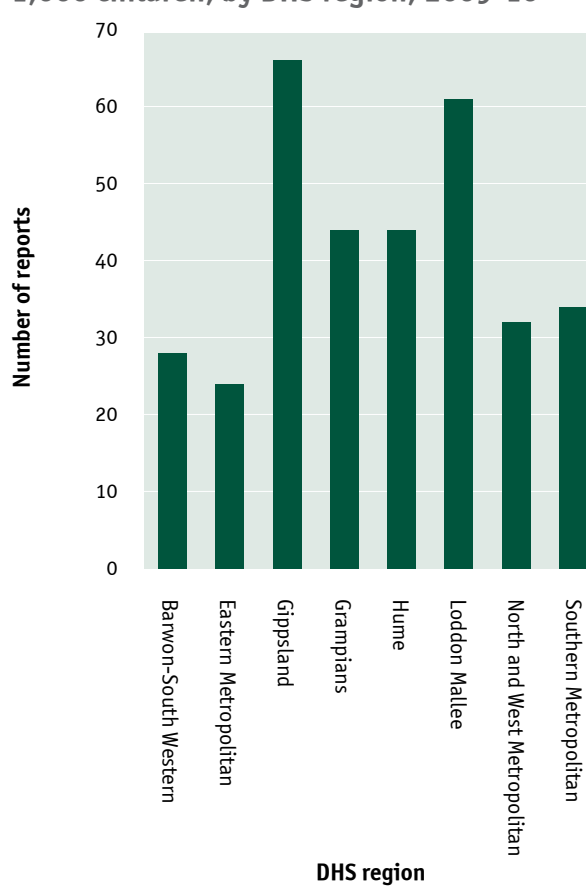
Source: Inquiry analysis of information provided by DHS

Figure 9.7 Child protection reports by DHS region, 2009-10



Source: Inquiry analysis of information provided by DHS

Figure 9.8 Child protection reports per 1,000 children, by DHS region, 2009-10



Source: Inquiry analysis of information provided by DHS and unpublished population data from DPCD
Note: Excludes reports where the region was not stated

Figure 9.9 shows that in 2010-11 the most common reasons for a child protection report were concerns over emotional harm (55 per cent) and physical harm (25 per cent), while reports for sexual harm or neglect accounted for 10 per cent each. The precise reasons for the rapid growth in reports for emotional harm are hard to determine in the absence of data about client complexity and characteristics. In other comparable jurisdictions there is a trend to increasing reports related to children being present in family violence incidents where the police are called to attend. It is possible this is part of the explanation in Victoria for the increasing reports of emotional harm. Similarly, the growth may relate to increased community and professional awareness of children's health and wellbeing and may reflect a widening concern of the community about the effects on children exposed to violence within the family.

In 2009-10, the largest number child protection reports were received from family members of the child, police and education providers (see Figure 9.10).

On average DHS received 130 child protection reports per day during the business week in 2009-10, however, these reports were not spread evenly. Fewer reports were received on weekends than weekdays and fewer reports were received in December and January, when many children were on school holidays. The highest number of reports were in February.

Reporting patterns about Aboriginal children

It is well established that Aboriginal children are over-represented in most areas of Victoria's statutory child protection system. In 2009-10 an estimated 9.4 per cent of children who were the subject of reports to DHS were Aboriginal (information provided to the Inquiry by DHS). However, Aboriginal children represent just 1.2 per cent of Victoria's child population (Department of Education and Early Childhood Development 2010, p. 34). Aboriginal children are therefore around seven to eight times more likely to be the subject of a report to DHS than non-Aboriginal children.

In 2009-10 the DHS regions with the highest number of Aboriginal children who were the subject of reports to DHS were: Loddon Mallee, North and West Metropolitan and Gippsland (see Figure 9.11).

The statutory response to a child protection report

As discussed earlier, all child protection reports go through an intake phase, where it is determined whether the report warrants an investigation by child protection practitioner or if it will be closed following advice. In addition, no further action may be required. Table 9.1 shows the outcomes of the intake phase for reports received in 2009-10.

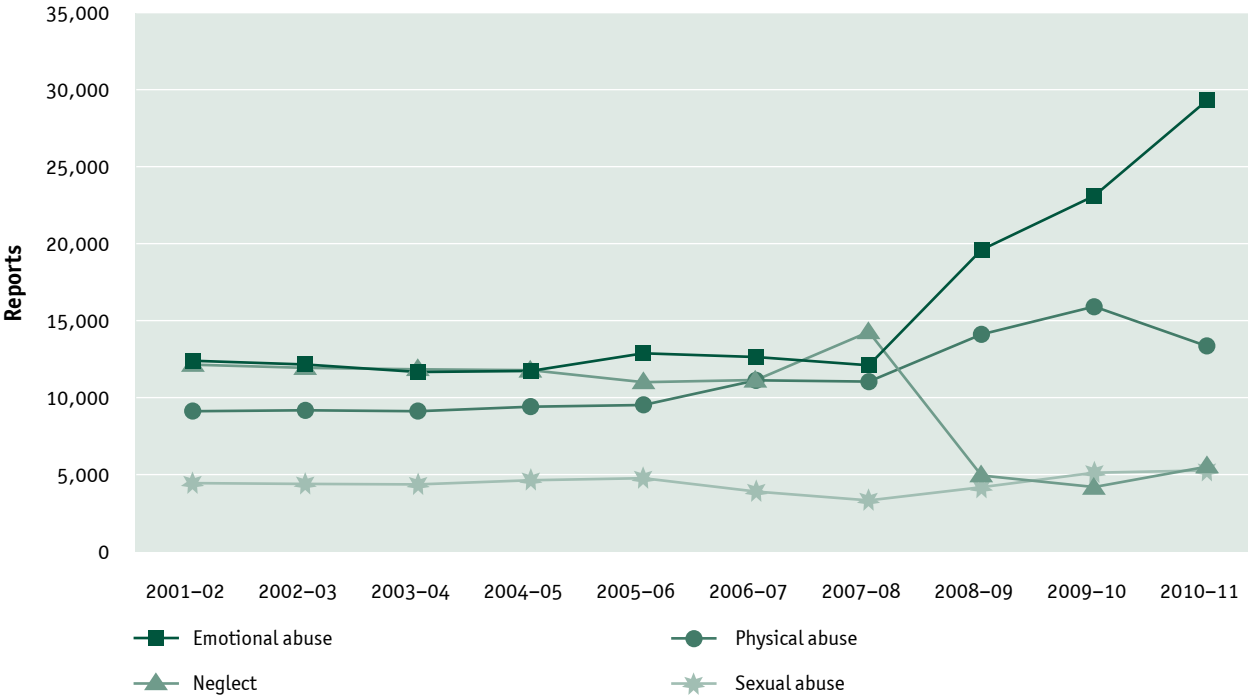
For 2009-10 overall, 29 per cent of reports to DHS were referred to an investigation, while two-thirds resulted in advice or information and were closed. Three per cent of reports resulted in no further action, due to either insufficient information or if the report has been determined to be inappropriate.

Table 9.1 Outcomes of the intake phase: child protection reports received in Victoria, 2009-10

Report outcome	2009-10	Comment
Investigation	29%	Reports proceeding to investigation phase
Advice/information	68%	This includes reports where advice was provided to the reporter and no further action was taken
No further action	3%	This includes 852 'inappropriate reports' as well as 738 reports where there was 'insufficient information' and no further action was possible
Total	100%	

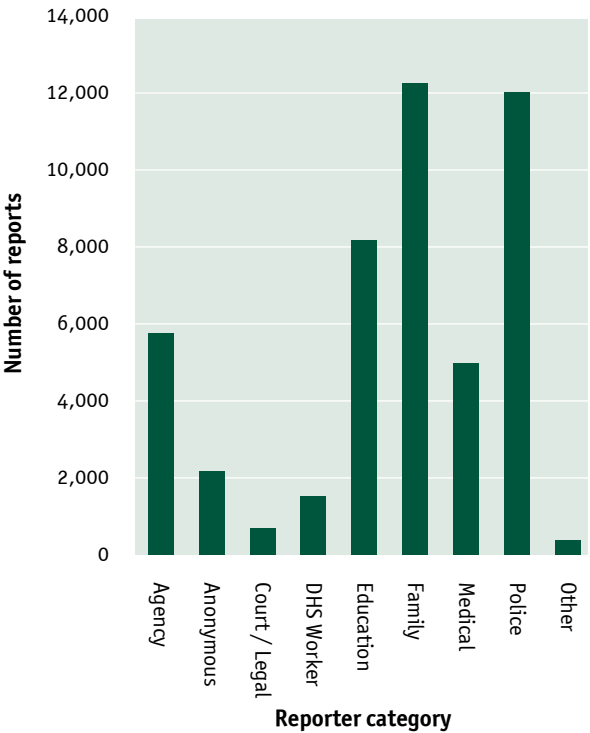
Source: Information provided by DHS

Figure 9.9 Child protection reports, by category of report, Victoria, 2001-02 to 2010-11



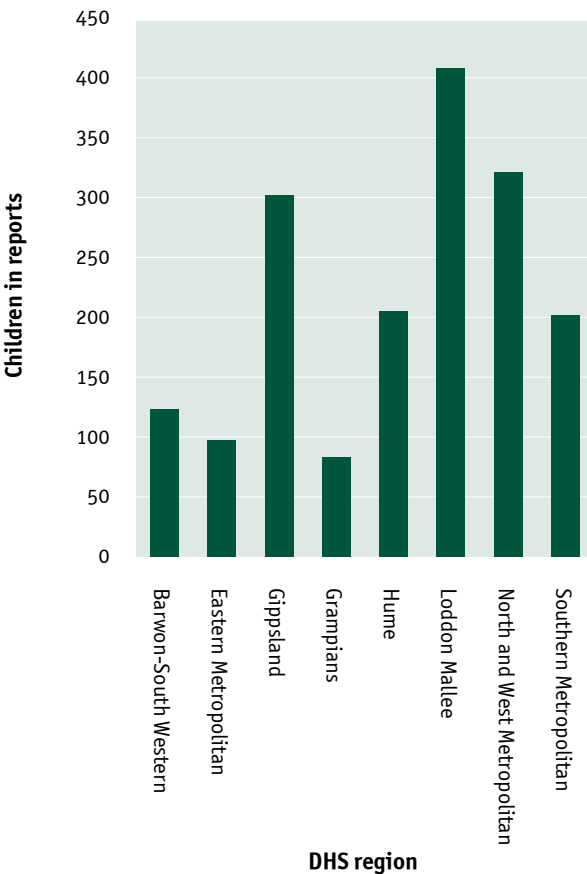
Source: Inquiry analysis of information provided by DHS

Figure 9.10 Child protection reports, by source of report, Victoria 2009-10



Source: Inquiry analysis of information provided by DHS
Note: Reports to DHS from Child FIRST are included under the ‘Agency’ category. There were 350 reports from Child FIRST in 2009-10.

Figure 9.11 Child protection reports of Aboriginal children, by DHS region, 2009-10



Source: Inquiry analysis of information provided by DHS

Referrals to and from Child FIRST

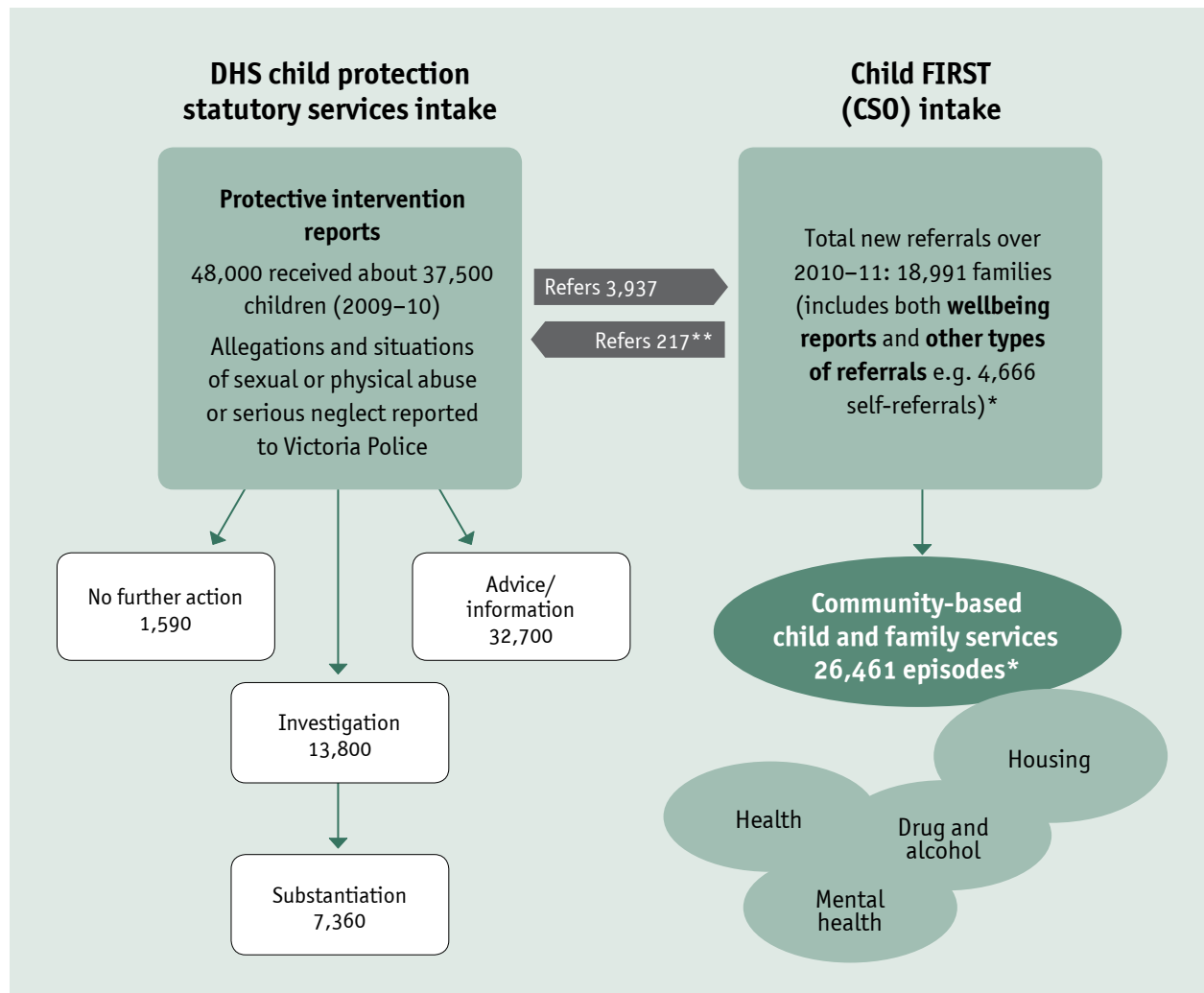
There is overlap between the families who access family support services funded by DHS and families whose children are the subject of reports to statutory child protection services. One way of measuring the extent of the common client group exists is to examine the referral rates between the Child FIRST intake and DHS.

Figure 9.12 presents the available data on referrals activity between statutory child protection services and Child FIRST.

During 2010-11, a total of 18,991 referrals were made to Child FIRST. Around 25 per cent of this figure, 4,666, were cases of self-referral (where a family voluntarily seeks assistance) while 21 per cent of this figure, 3,937, were referrals from statutory child protection (information provided by DHS). Child FIRST made 217 protective intervention reports during the same period (information provided by DHS).

In October 2011, the Victorian Ombudsman reported that in the Loddon Mallee region referrals of reports from DHS to Child FIRST (operated by St Luke's Anglicare) had risen over the preceding three years from 155 referrals in 2008-09 to 216 referrals in 2010-11 (Victorian Ombudsman 2011d, pp. 32-33).

Figure 9.12 Referral activity and Child FIRST and statutory child protection services, 2010-11 (some data from 2009-10)



Source:

*Information provided by DHS. The total number of family services cases provided in 2009-10 was 26,223, against the target of 23,150. The 2010-11 target is 24,910 (Victorian Government 2010b, p. 224).

**Note: The 2009-10 figure was 356.

9.3.2 The investigation phase

A total of 13,941 investigations were conducted in relation to the 55,718 child protection reports received by DHS in 2010-11. Based on the Inquiry's analysis of 2009-10 data, reports of alleged physical harm or sexual harm were more likely to be investigated than some other reports, for example, emotional harm. Similarly, if a child was the subject of multiple reports in 2009-10 their case was twice as likely to be investigated as the average.

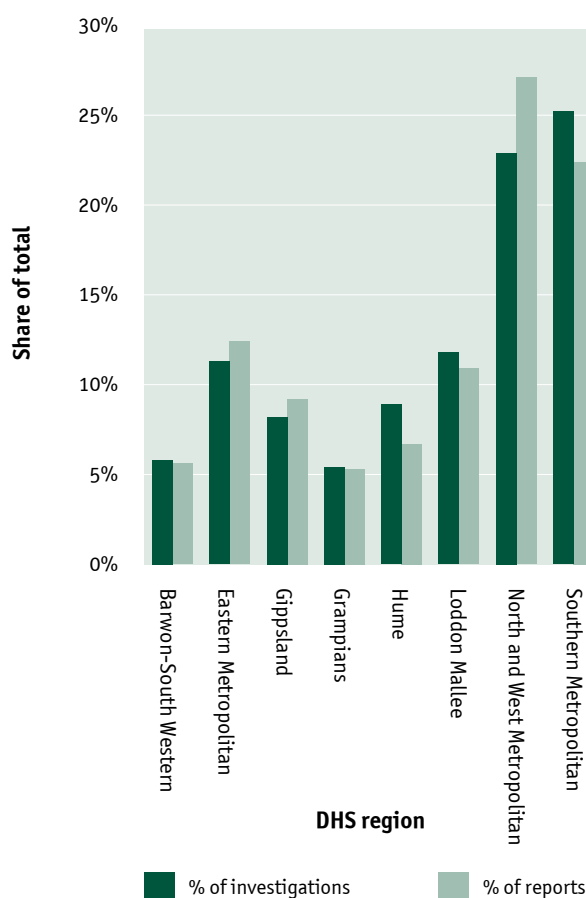
These trends are likely to reflect prioritisation decisions based on the risk of significant harm presenting to a child. Such decisions are required when resources are constrained and investigations cannot be conducted on every report.

There is some regional variation on the number of investigations carried out (see Figure 9.13). Although broadly similar, the Hume, Loddon Mallee and Southern Metropolitan regions have a higher share of investigations than reports, implying that a higher proportion of reports received in these regions in 2009-10 were investigated. The Southern Metropolitan region had a significantly lower share of investigations than reports.

Table 9.2 summarises the outcomes of investigations initiated in 2009-10. Overall:

- Just over half of investigations result in the report being substantiated;
- Of substantiated reports, around 70 per cent proceeded to protective intervention; and
- Less than 10 per cent of not-substantiated reports were referred to support services.

Figure 9.13 Child protection reports and investigations, by DHS region, 2009-10: percentage distribution



Source: Inquiry analysis of information provided by DHS

Table 9.2 Outcomes of investigations for child protection reports received in Victoria, 2009-10

Investigation outcomes	Substantiated	Not-substantiated	Total
Protective intervention	5,037	0	5,037
Referral to family services	22	423	445
Advice / no further action	2,266	5,963	8,229
Total	7,325	6,386	13,711

Source: Inquiry analysis of information provided by DHS

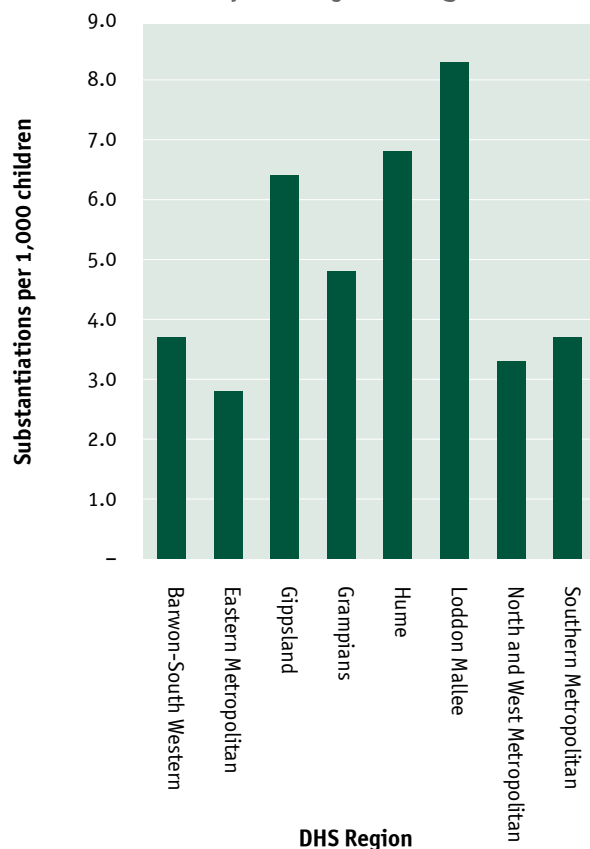
Note: Figures were only included where the investigation outcome was recorded, hence totals are somewhat lower than those reported elsewhere in this Report).

Substantiations

Figure 9.14 shows the number of substantiations based on 2009-10 reports per 1,000 children for each of the DHS regions, the region with the highest rate of substantiations per 1,000 children is Loddon Mallee (8.3), followed by Hume (6.8) and Gippsland (6.4). There is a significant difference in the substantiation rates between regions. For example a child in the Loddon Mallee region is three times as likely to be the subject of a substantiation than one in the Eastern Metropolitan region.

The rate of substantiations as a proportion of investigations was 52.7 per cent overall; however, this rate varies between DHS regions. Southern Metropolitan (44.2 per cent), Gippsland (48.0 per cent) and Hume (51.8 per cent) had a lower proportion of substantiations compared with investigations, while Barwon-South Western (58.3 per cent) and Eastern Metropolitan (58.2 per cent) had the highest rates of substantiations (see Figure 9.15).

Figure 9.14 Child protection substantiations per 1,000 children, arising from 2009-10 reports, by DHS region



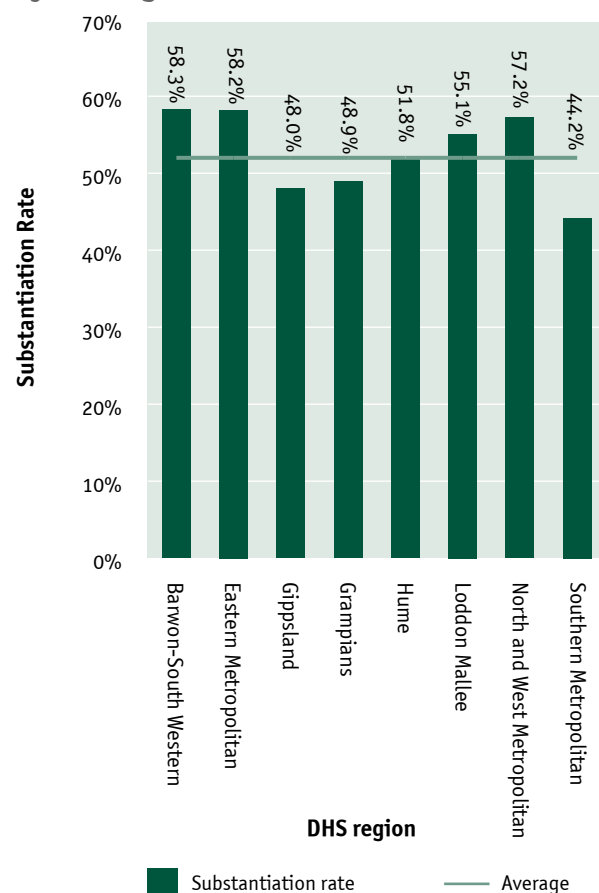
Source: Inquiry analysis of information provided by DHS and Department of Planning and Community Development (DPCD) unpublished population data
Note: Excludes substantiations where the region was not stated

As will be seen in the following section, which looks at the performance of statutory child protection services, substantiation rates are a key measure of effectiveness. Investigation and substantiation rates are also discussed further in this chapter in the context of demand and capacity constraints at section 9.5.1.

9.3.3 The protective intervention and assessment phase

In 2010-11 there were 5,897 cases that proceeded to the protective intervention and assessment phase, equivalent to just over 10 per cent of the total number of reports received. As of June 2011 there were just under 2,000 cases in the protective intervention stage (information provided to the Inquiry by DHS).

Figure 9.15 Child protection substantiation rates arising from 2009-10 reports, by DHS region



Source: Inquiry analysis of information provided by DHS
Note: Substantiation rate is calculated as the per cent of investigations that were substantiated.

9.3.4 The protective order phase

There are a variety of orders to obtain lawful authority to mandatorily intervene in the child's family, for example, to further supervise or monitor a family, or potentially, to make alternative arrangements for their care.

It is not uncommon for multiple orders to be made in relation to the one child. For example a court may issue a warrant for the removal of a child from their parents, followed by an interim accommodation order, followed by a protection order. In 2010-11, there were 15,612 orders, warrants and undertakings issued in relation to 5,171 children. The nature of these orders is discussed in detail in Chapter 15 dealing with court processes.

Children on care and protection orders

At June 2011, Victoria had around 6,700 children on care and protection orders compared with around 4,700 in 2001 (see Figure 9.16). The growth in the number of children receiving statutory child protection services has flow on effects to the volume of applications and orders sought in the Children's Court and to the provision of out-of-home care services. These issues are discussed further in Chapters 10 and 15 of this Report.

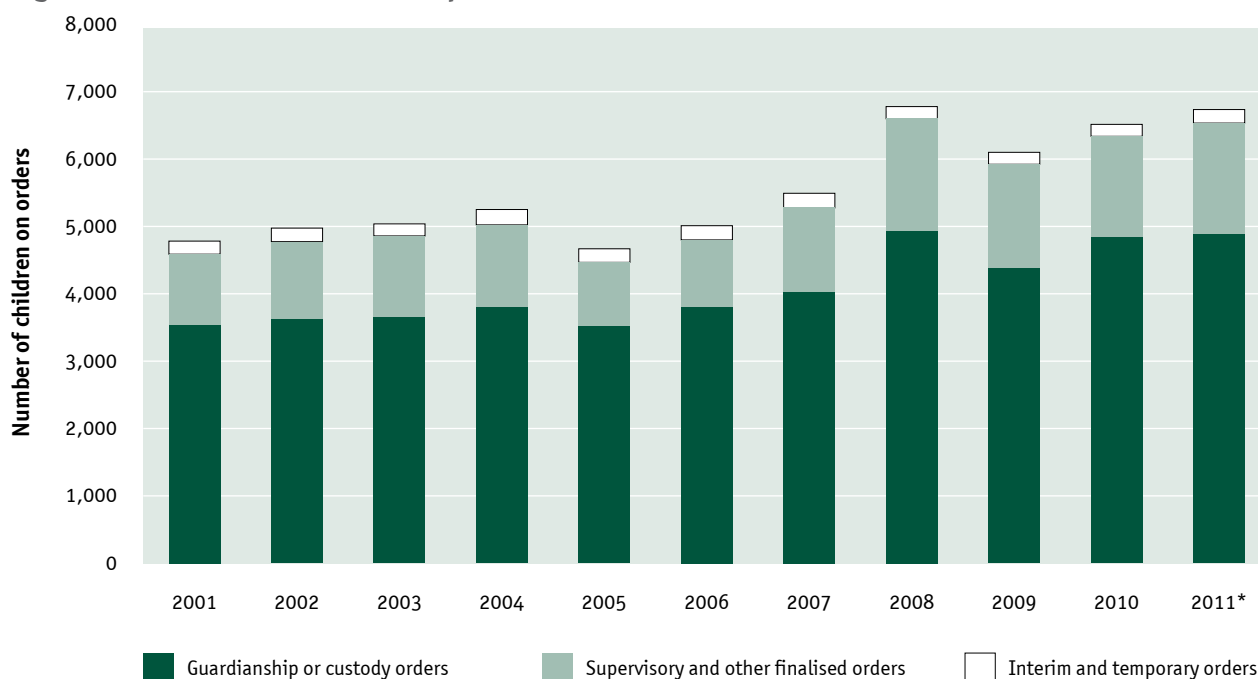
9.4 The performance of statutory child protection services

A range of internal and external performance measures are used for the statutory child protection system. These include broader whole-of-government wellbeing indicators measuring Victorian children's health, budget performance measures used by the Victorian Department of Treasury and Finance, internal monitoring carried out by DHS and national performance indicators developed by the Australian Institute of Health and Welfare (AIHW) and the Productivity Commission to inform the annual Report on Government Services (ROGS) publication.

The practice manual also contains a series of rules that stipulate standards to be applied for statutory child protection services. For example, these might include the number of days within which a particular activity or action (such as an investigation) must take place.

Aside from the indicators contained in the publications just listed, performance results of statutory child protection services against the internal standards applied by DHS are not generally publicly available.

Figure 9.16 Children on care and protection orders, Victoria, June 2001 to June 2010



Source: SCRGSP 2011c, Table 15A.52

* Provided to the Inquiry by DHS

National performance indicators

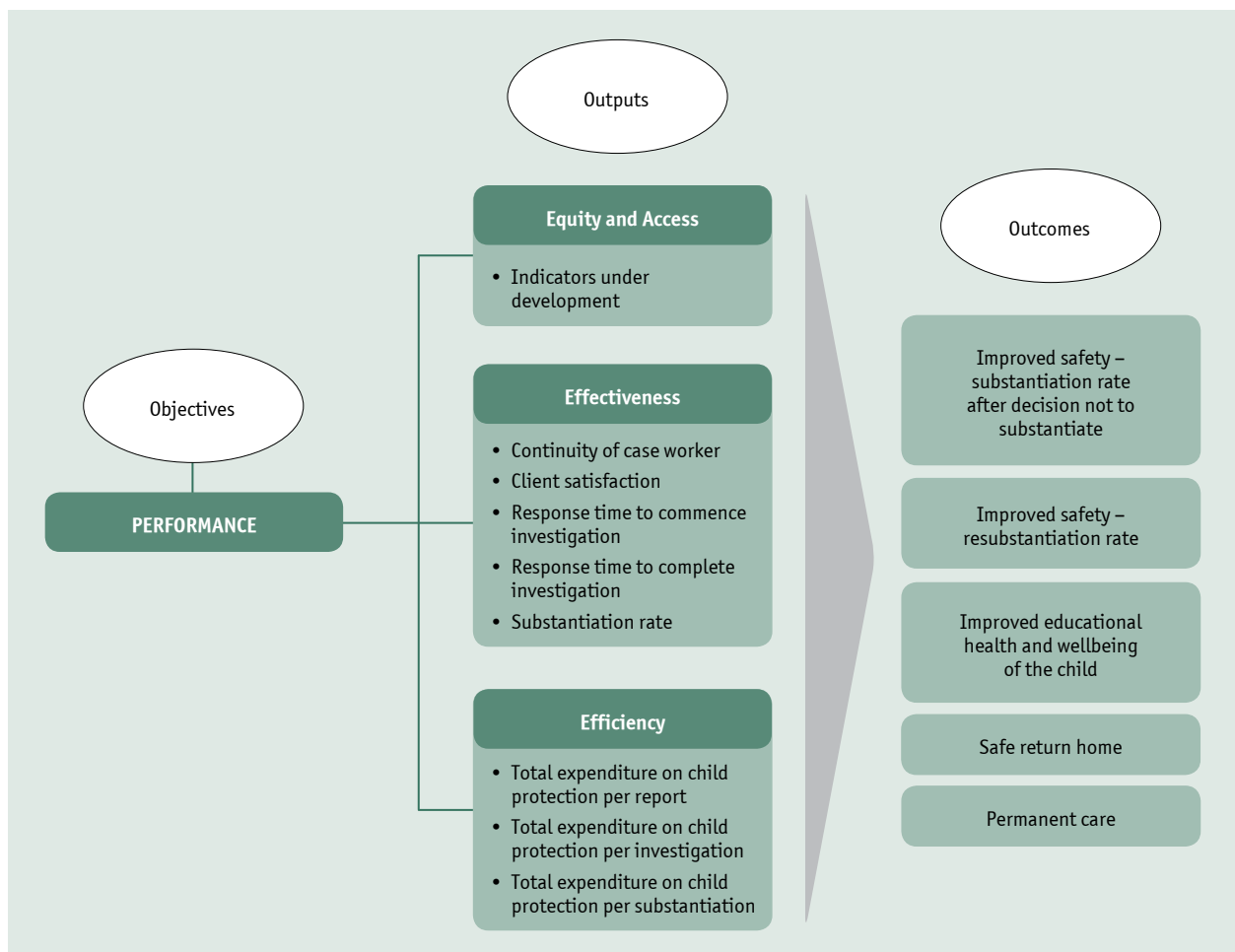
As set out in Figure 9.17, Australia's national performance indicator framework for child protection and out-of-home care outlines three major objectives for child protection and out-of-home care: effectiveness, efficiency, and equity and access (the latter a combined objective). Indicators have not yet been developed to measure equity and access.

As noted in Chapter 4, gaps in available performance data, particularly over time, prevents a clear picture emerging of the effectiveness and efficiency of statutory child protection services. There are a number of indicators for which data is not collected or where trend information is unavailable to show changes over time.

In relation to output measures, continuity of case worker and client satisfaction is not generally available. Of the outcome measures listed above, there is no clear and publicly available measure of the educational health and wellbeing outcomes of children or young people receiving statutory child protection services. The Inquiry has recommended the development of a holistic performance indicator framework in Chapter 6 to address these issues. Other ways to improve system transparency are covered in Chapter 21 on regulation and governance and Chapter 20 on the role of government agencies.

With the above limitations in mind, the next section reviews available performance information and presents some comparative analysis of Victoria's statutory services with other Australian jurisdictions.

Figure 9.17 National performance indicator framework for statutory child protection services



Source: Adapted from AIHW 2006, p. 10

9.4.1 Effectiveness measures

The 2011-12 Victorian State Budget projects an expected 59,700 reports to child protection in 2011-12, an increase of 7 per cent over the figure for 2010-11. This increase in reporting trends is analysed in more detail through the major issues discussion in this chapter at section 9.5.

Although Victoria has the second highest figure for the number of children who are the subject of a report in Australia, on a per-capita basis Victoria has the third lowest number of children who are the subject of a report (see Figure 9.18).

Differences in jurisdictional approaches to child protection can influence rates of reporting, for example, approaches to mandatory reporting or the availability of universal and secondary prevention services.

Client satisfaction

A partial picture of client satisfaction outcomes for statutory child protection service can be derived from a survey report prepared by the Social Research Centre at the Queensland University of Technology (QUT) for DHS. The survey sought views from the principal carers of clients receiving services from child protection, family services and placement (or out-of-home care) services. Care must be taken with use of the results as they are the early findings of an incomplete survey of principal carers and parents. QUT observes, however, that the interim data set is sizeable and allows for robust analysis of recent reforms (Lonne et al. 2011, pp. 1, 38).

The focus of questions posed by researchers to parents and carers was around the provision of information about services, their utility, decision-making processes and whether safety levels and parenting had improved (Lonne et al. 2011, p. 28).

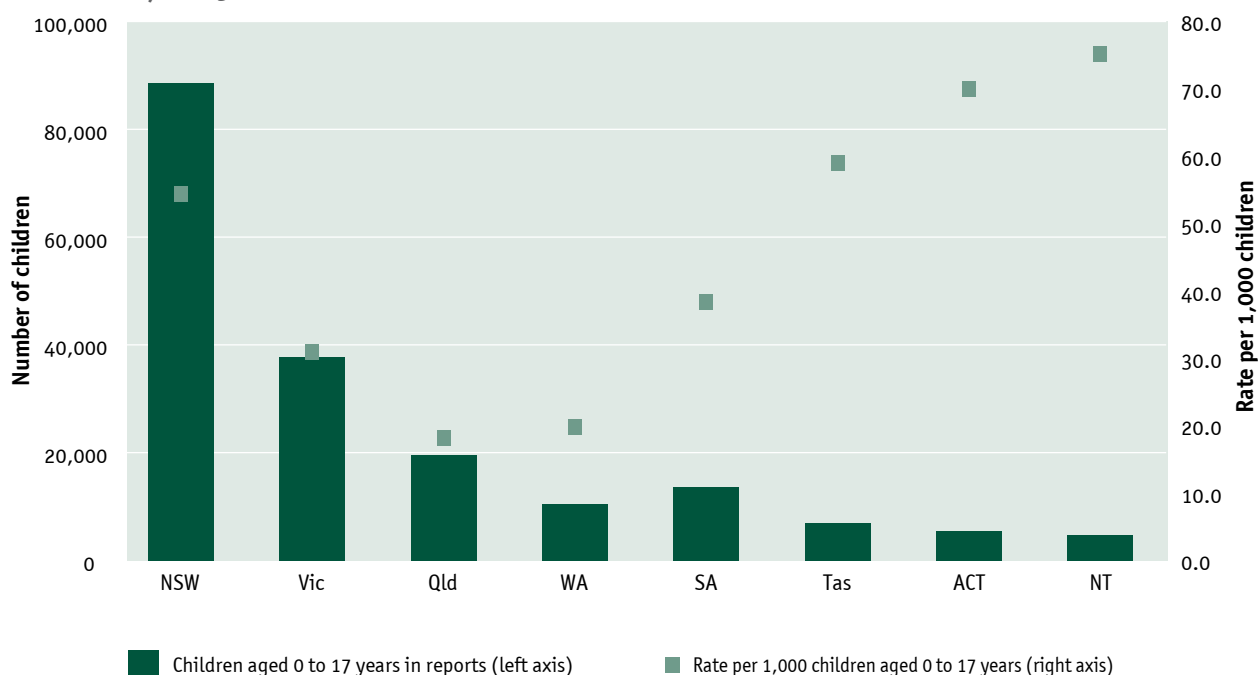
Overall, the survey report found that parent and carer attitudes towards statutory child protection services were mixed, compared with their views about family services. Roughly half believed that the statutory child protection assistance provided had not improved their parenting skills nor the child's health and wellbeing. The other half of respondents, however, thought that the child's wellbeing or health had improved since the provision of statutory child protection services. These latter respondents attributed the positive outcomes for families to the provision of statutory intervention services (Lonne et al. 2011, p. 36).

Response times

For those reports assessed as requiring an immediate response, DHS has internal targets for response times to visit 97 per cent of these cases within two days (DHS 2011j). In 2010-11, performance against this target was 94.1 per cent (DHS 2011b, p. 27).

If a report is not considered urgent, a DHS visit must occur within 14 days (DHS 2011k, advice no. 1172). DHS internally monitors performance against this 14 day requirement for visiting.

Figure 9.18 Children in child protection reports and rates per 1,000 children, states and territories, 2009-10



Source: SCRGSP 2011c, Table 15A.8

DHS advised the Inquiry that, while often cases have been visited within the required timeframe, this may not be recorded accurately or consistently for each sibling within a given family. The standard therefore is used as a management or supervisory mechanism and does not represent an accurate measure of the proportion of cases visited.

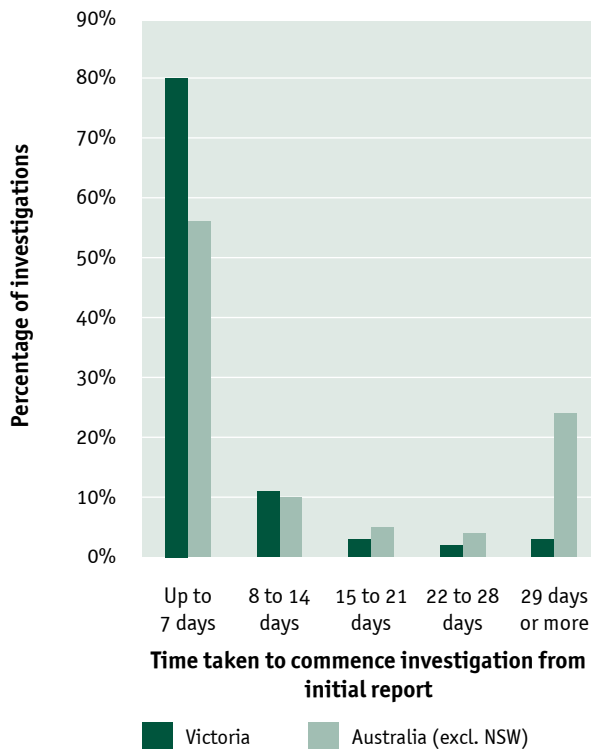
The DHS *Policy and Funding Plan 2010-12* sets a target for the percentage of investigations commencing within 14 days of a report to child protection. This target is 90 per cent.

Time taken to commence an investigation is reported in ROGS, which shows that, in 2009-10, 80 per cent of investigations in Victoria were commenced within seven days of receiving a child protection report and a further 10 per cent between eight and 14 days. It can be seen from Figure 9.19 that Victoria performs well by comparison with the whole of Australia on investigation commencement.

The time taken to complete an investigation is longer in Victoria than for other jurisdictions (see Figure 9.20).

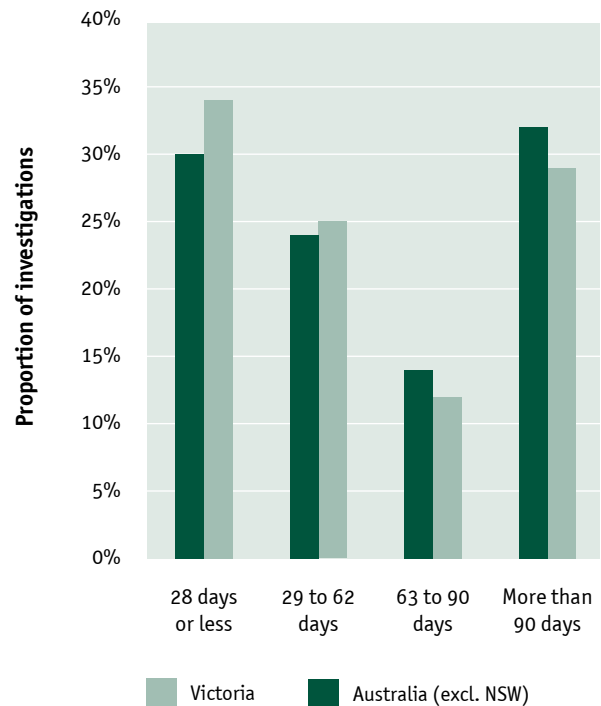
Figure 9.21 shows that the time taken to complete investigations has increased over the three years to 2009-10, with a smaller proportion of investigations completed in 28 days and a larger proportion exceeding 90 days.

Figure 9.19 Child protection reports and time to commence an investigation, Victoria and Australia, 2009-10



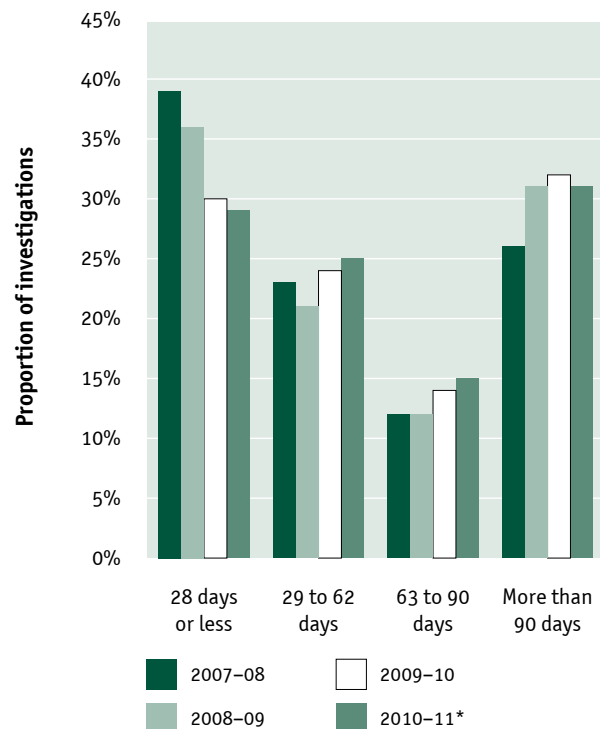
Source: SCRGSP 2011c, Table 15A.14

Figure 9.20 Child protection reports and time to complete an investigation, Victoria and Australia, 2009-10



Source: SCRGSP 2011c, Table 15A.15

Figure 9.21 Child protection reports and time to complete an investigation, Victoria, 2007-08 to 2009-10



Source: SCRGSP 2011c, Table 15A.15

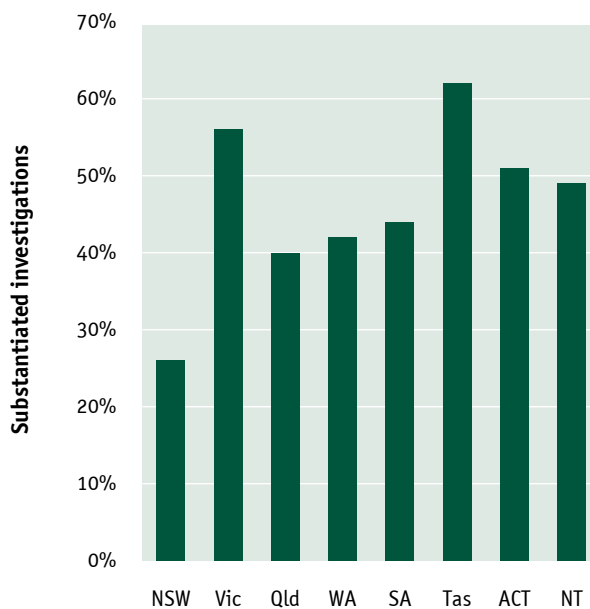
* Provided to the Inquiry by DHS

Substantiation rates

As noted previously, the primary outcome of an investigation is to either substantiate or not substantiate the report of concern. Based on reports received in 2010-11, there were 13,941 investigations, of which 12,979 had been completed when data was provided to the Inquiry. This resulted in an estimated 7,643 substantiations, or a substantiation rate of 59 per cent.

Figure 9.22, which is taken from ROGS, shows substantiations as a proportion of completed investigations in 2009-10. It shows that Victoria had the second highest rate of substantiation of the states and territories, behind Tasmania (note that ROGS shows a slightly higher proportion of substantiations from investigations than DHS data).

Figure 9.22 Child protection substantiation rates, states and territories, 2009-10



Source: SCRGSP 2011c, Table 15A.14

Note: Substantiation rate is calculated as the per cent of investigations that were substantiated

Performance indicators for services provided to children in the protective intervention and order phase

There are some overlaps in relation to the protective intervention and assessment phase and the protective order phase and fewer published performance measures exist for the protective intervention and assessment phase. Figure 9.23, prepared by the Inquiry using information provided by DHS, shows the days between receiving a child protection report and the commencement of the protective intervention and assessment phase. While a large number of cases proceed from report to this phase within a week, 50 per cent take longer than 31 days and 20 per cent take greater than 90 days. Comparative data across Australia is unavailable for these measures.

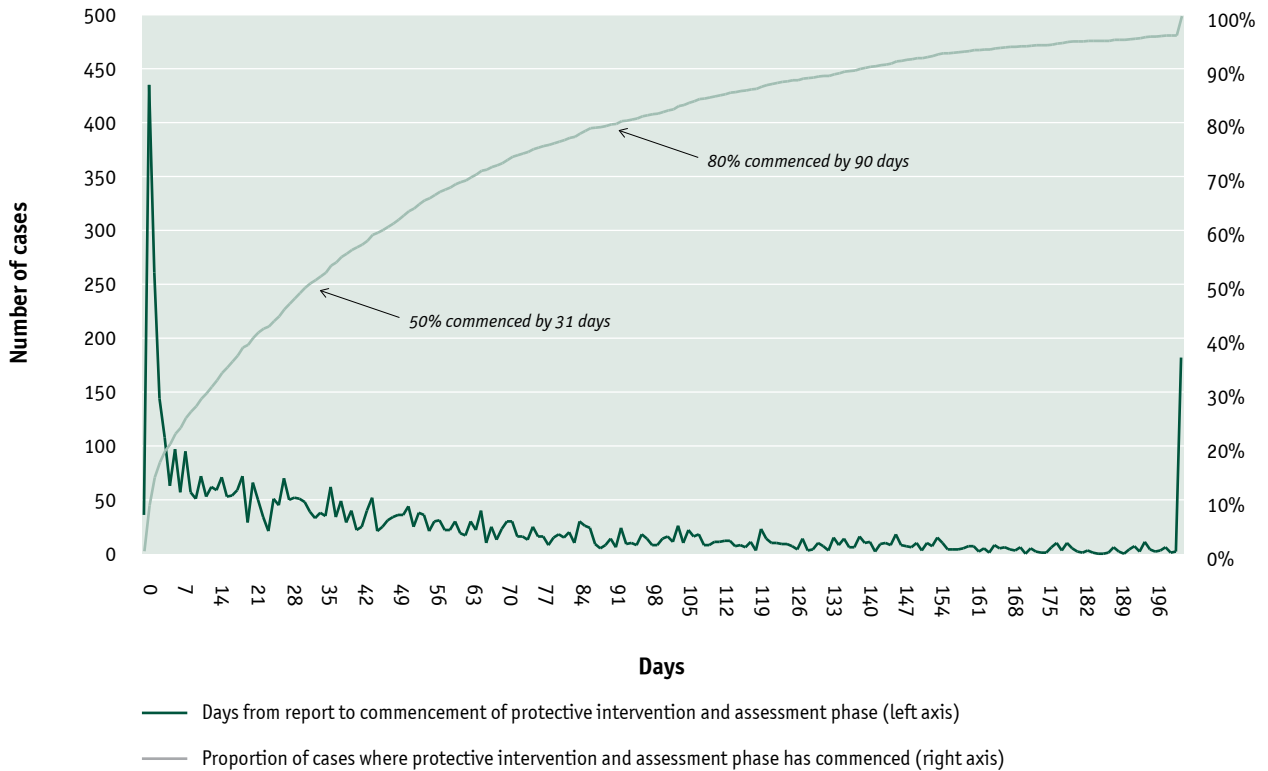
Figure 9.24 shows the time it takes from the date of the report to the conclusion of the protective intervention and assessment phase and the length of that phase. The protective intervention and assessment phase is concluded either with progression to the protective order phase or case closure. This is the case within 90 days for around a quarter of cases, while just under half of cases remain in the phase after 150 days after the date of the report. Comparative data across Australia is also unavailable for this analysis.

As noted previously, the number of children on care and protection orders has increased in Victoria over the past decade. Despite this Victoria still has the lowest rate of children on these orders per capita, as shown in Figure 9.25.

There are few other measures of system performance in terms of orders. ROGS has previously included measures of the educational outcomes for children on guardianship or custody orders, in terms of reading and numeracy. This information was published for school years three, five and seven, but has not been reported since 2006.

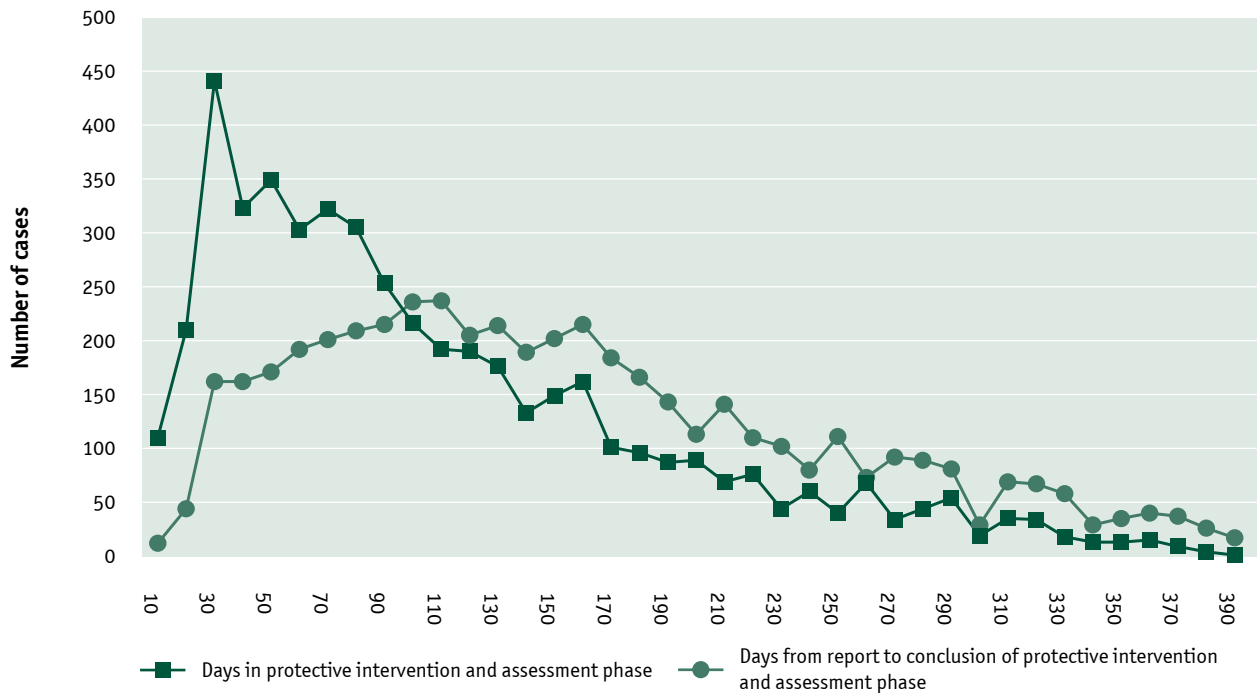
The remaining performance measures relating to this phase typically relate to children in out-of-home care. These are discussed in Chapters 10 and 11.

Figure 9.23 Child protection reports: days from receipt of report to commencement of protective intervention and assessment, Victoria, 2009-10

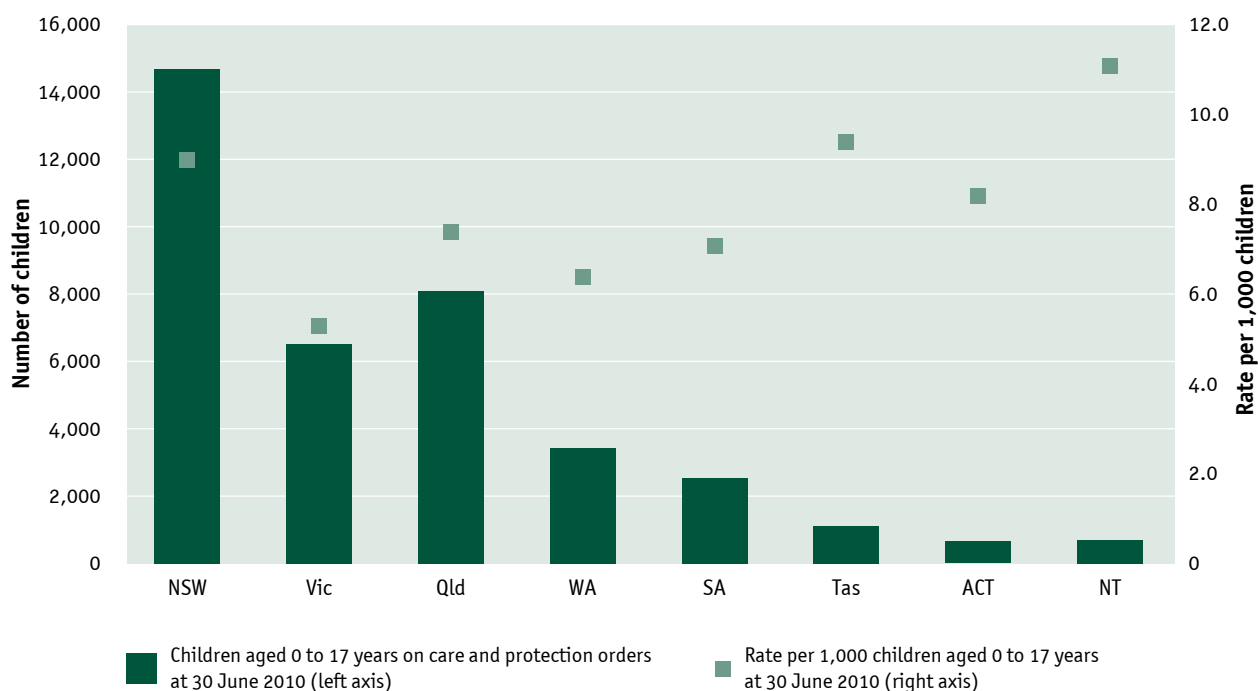


Source: Inquiry analysis of information provided by DHS

Figure 9.24 Child protection reports: days from receipt of report to conclusion of protective intervention and assessment phase and days in protective intervention and assessment phase, Victoria, 2009-10



Source: Inquiry analysis of information provided by DHS

Figure 9.25 Children on care and protection orders, number and rate per 1,000 children, states and territories, 2009-10

Source: SCRGSP 2011c, Table 15A.8

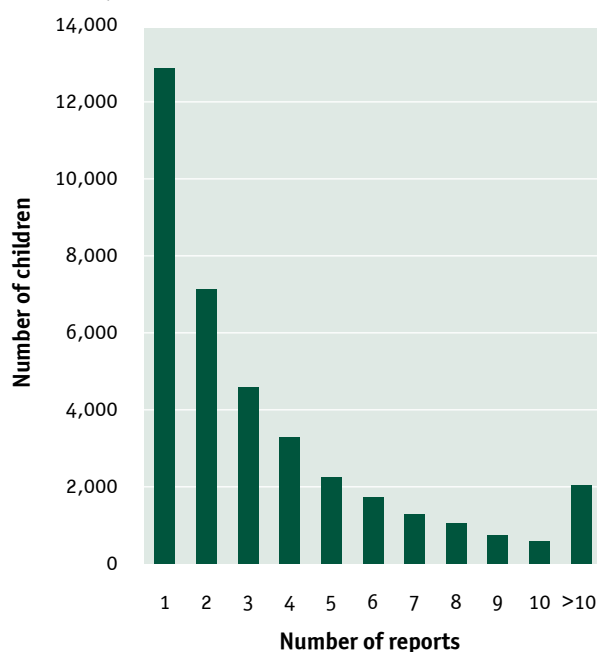
9.4.2 Outcomes measures

The national performance indicator framework measures outcomes through improved safety for children. The incidence of children coming back into contact with statutory child protection services is a proxy for improved safety as there are no direct measures of the incidence of child abuse and neglect.

Measuring a child's return to the statutory system can be addressed in two ways. The first is whether a child has presented multiple times to DHS over the course of their life, that is, covering from 0 to 18 years of age. The second method is more concerned with the proximity of the interactions of the child presenting to DHS, that is, measuring whether a child has been re-reported or re-substantiated within a three or 12 month period of the previous time they were in contact with statutory child protection services.

Re-reporting trends

There is evidence that a significant proportion of children are the subject of repeated reports to DHS over a sustained period of time. Figure 9.26 shows the reporting history of children at a point in time, for whom reports were made in 2009-10. Two thirds of these children have been the subject of multiple reports and a significant number of children have been the subject of a very large number of reports, with more than 2,000 children having been the subject of more than 10 reports to child protection intake over their lifetime.

Figure 9.26 Children in child protection reports in 2009-10, by number of reports to date, Victoria

Source: Inquiry analysis of information provided by DHS

Figure 9.27 shows the re-reporting rate over time for statutory child protection services. These reports cover a child's reporting history from 0 to 18 years of age.

Resubstantiation trends

Substantiation trends are considered in two contexts:

- The number of substantiations that occur after DHS has previously investigated a child or young person and made a decision not to substantiate; and
- The number of substantiations that occur after a substantiation of harm has previously been found for a child or young person.

Previous decisions not to substantiate

In relation to decisions not to substantiate, the subsequent substantiation rate within 12 months has decreased significantly over time and sits currently at around 10 per cent. This suggests that statutory child protection is more effectively identifying cases of abuse and neglect.

The Victorian Budget sets targets for DHS concerning where children were previously the subject of a decision not to substantiate. DHS has a target of 5 per cent for the number of those children who are then subsequently the subject of a substantiation within three months of their case being closed.

In 2010-11 DHS bettered this target, with 2.29 per cent of these cases re-substantiated within three months (DHS 2011b, p. 27).

Figure 9.27 illustrates, while the re-reporting rate has increased since 2004-05, the proportion of reports that are re-reports in 2011 (as against new reports) is largely the same as it was in 2004-05; around 64 per cent of total reports are re-reports.

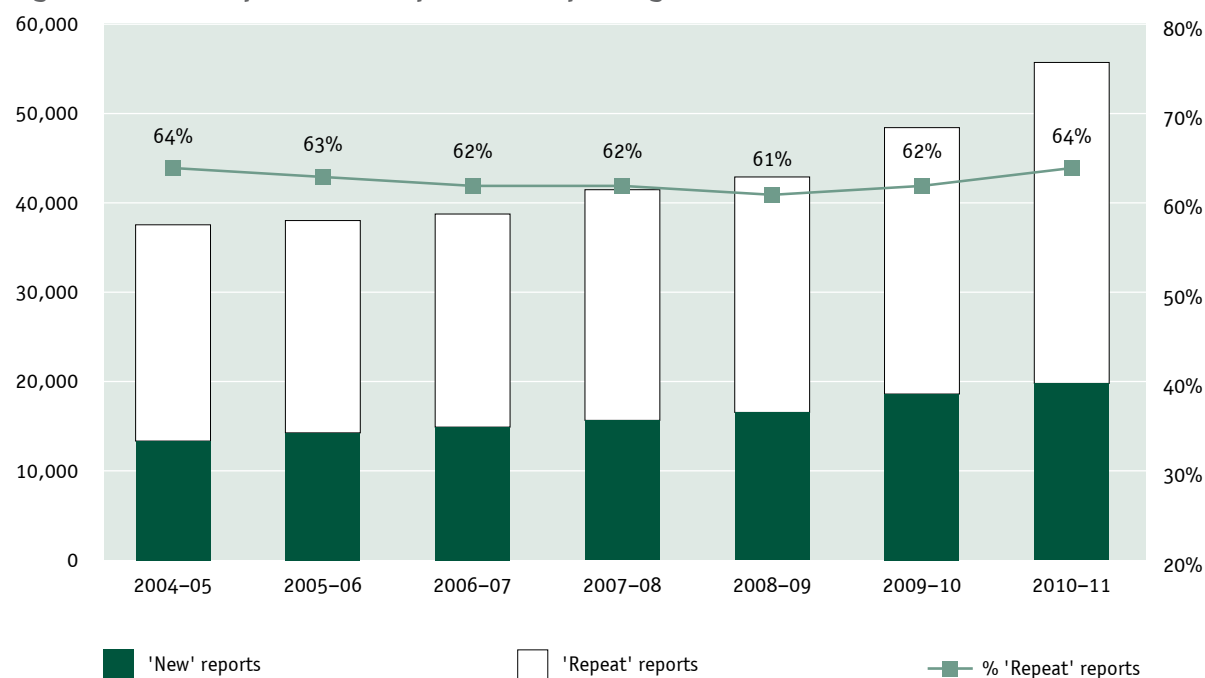
While rates of substantiations after a decision not to substantiate have generally been decreasing in Victoria over recent years, in 2008-09 Victoria had a greater number of substantiations within 12 months of a decision not to substantiate than Queensland and Western Australia, and a lower rate than in the remaining jurisdictions (see Figures 9.28 and 9.29).

Substantiations after a previous substantiation of harm has been found

A more complex picture emerges with resubstantiation patterns after substantiations have previously been found. As can be seen from Figure 9.30, once a child has been the subject of a previous substantiation, the resubstantiation rate rose in 2008-09.

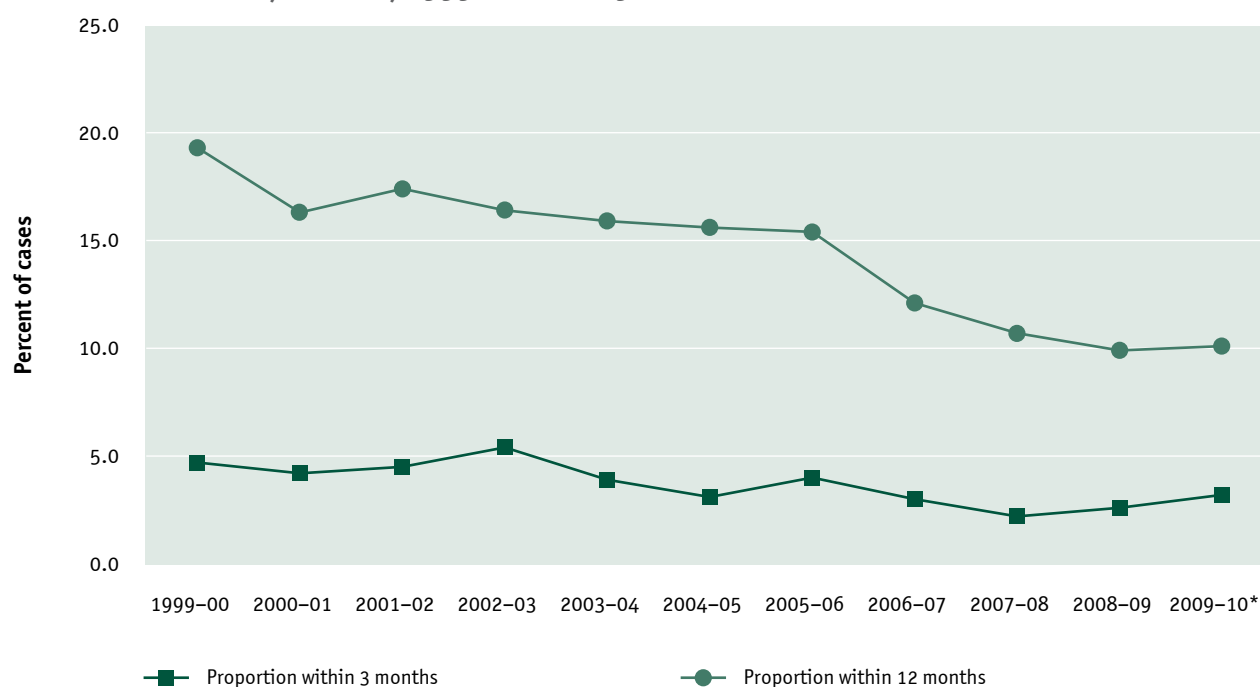
The Victorian Budget has a target of 15 per cent for protective cases being re-substantiated within 12 months of case closure. DHS bettered this target in 2010-11, with 10.3 per cent of cases re-substantiated (DHS 2011b, p. 27). Figure 9.31 illustrates how Victoria performs comparatively well in this measure by comparison with other jurisdictions.

Figure 9.27 Child protection reports: re-reporting rate, Victoria, 2004-05 to 2010-11



Source: Information provided by DHS

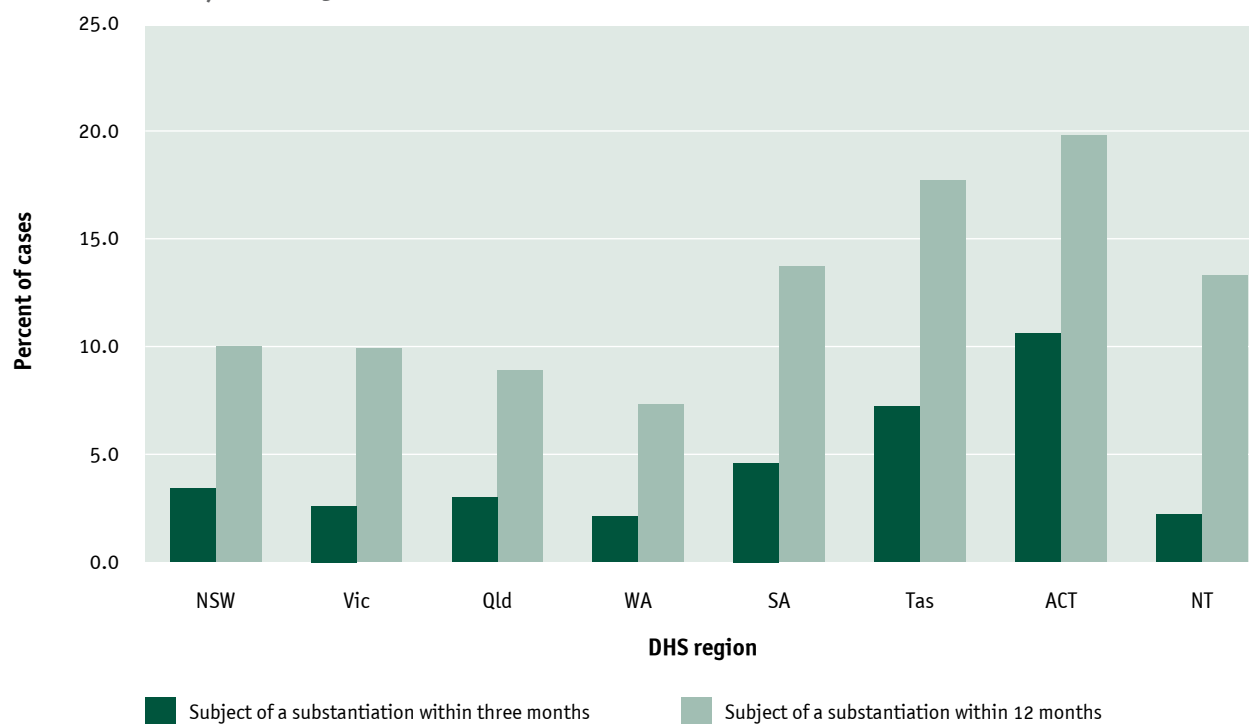
Figure 9.28 Child protection substantiation rates 3 months and 12 months after a decision not to substantiate, Victoria, 1999-00 to 2009-10



Source: SCRGSP 2011c, Table 15A.56

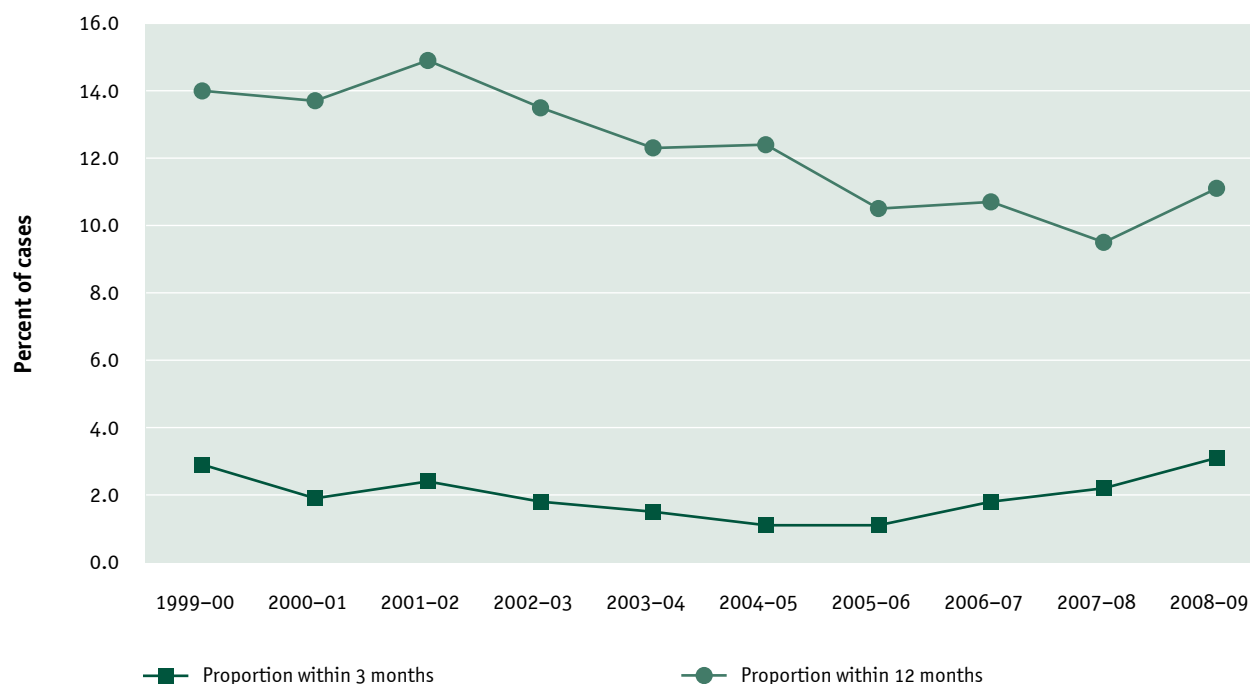
* Provided by DHS

Figure 9.29 Child protection substantiation rates after a decision not to substantiate, states and territories, 2008-09



Source: SCRGSP 2011c, Table 15A.9

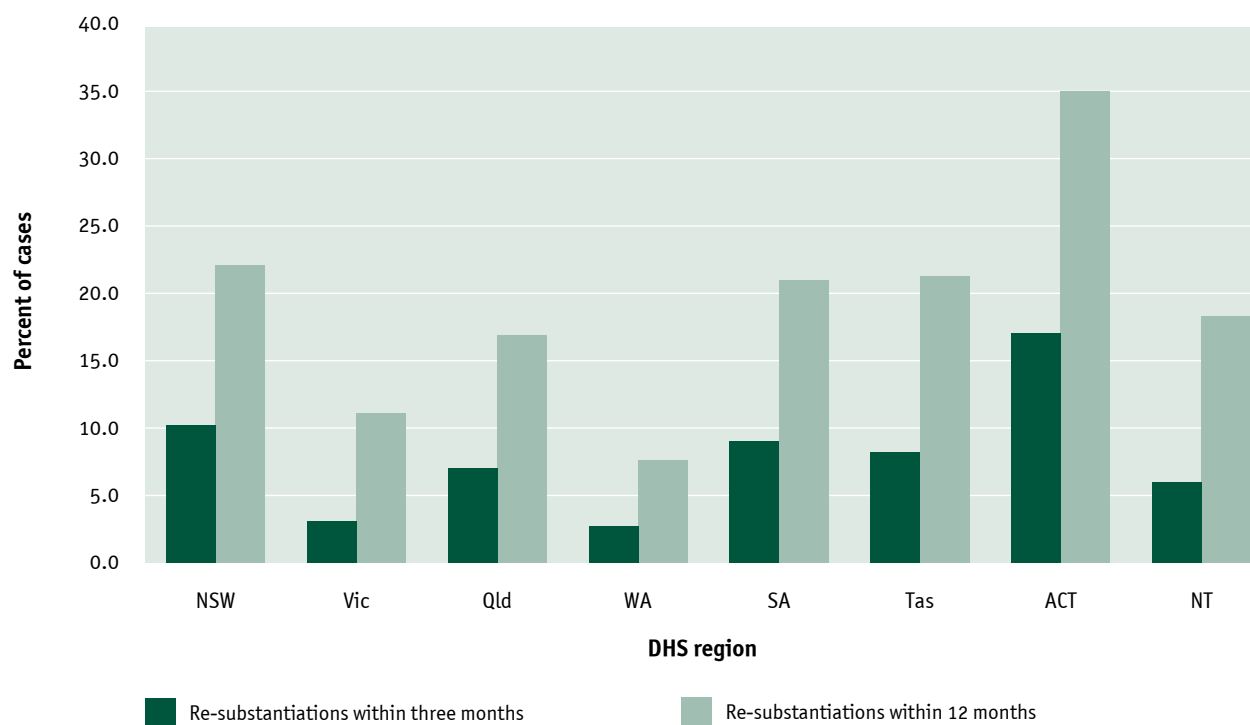
Figure 9.30 Child protection resubstantiation rates within 3 and 12 months of substantiation, Victoria, 1999-00 to 2008-09



Source: SCRGSP 2011c, Table 15A.55

Note: DHS have advised that a counting rule error has affected the resubstantiation rates presented in this chart. Accordingly, only published ROGS data has been presented. DHS is revising its resubstantiation calculations; however, these revisions will not be prepared in time for the ROGS 2012 publication.

Figure 9.31 Child protection resubstantiation rates within 3 and 12 months of substantiation, states and territories, 2008-09



Source: SCRGSP 2011c, Table 15A.9

Children who were the subject of multiple reports have similarly often been the subject of multiple substantiations. For the 37,500 children who were the subject of a child protection report in 2009-10, just under 6,000 have been the subject of more than one substantiation (see Figure 9.32).

Also concerning, is the Inquiry's analysis of the number of substantiations that a child is likely to have over their lifetime. The Inquiry examined the substantiation history of children for whom abuse had been substantiated in 2009-10. Table 9.3 shows previous statutory child protection interactions for children who were aged five, 10 and 15 at the time of their latest substantiation in 2009-10.

Table 9.3 shows, around half of these children for whom substantiated abuse was found in 2009-10 have been involved in multiple substantiations. Often there are many years between these incidents. Figures 9.33–9.35 show the proportion of these children for whom substantiated abuse was first found at an earlier age. Regardless of the age of the child in 2009-10, there was a significant proportion of children for whom substantiated abuse was first found when they were very young children, many years before abuse was again substantiated in 2009-10.

Other measures

The *DHS Annual Report 2010-2011* publishes information about two specific measures:

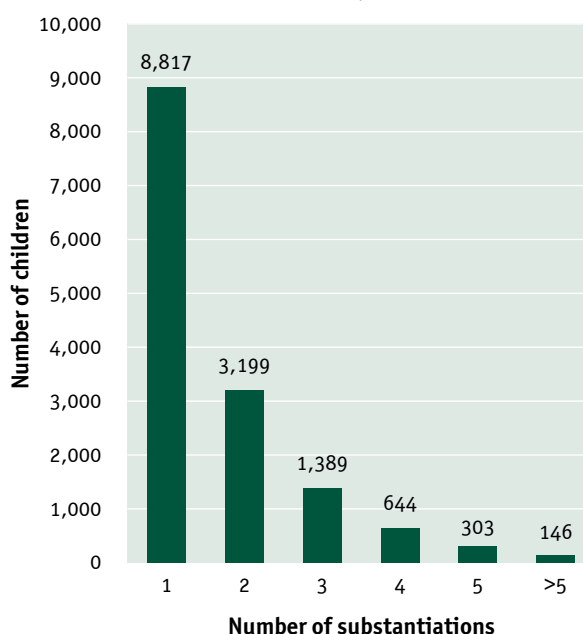
- Child protection practitioners receiving regular supervision (which was 81 per cent in 2010-11); and
- Unallocated cases (which was 7.8 per cent at June 2011) (DHS 2011b, p. 60).

Supervision rates are a quality control mechanism used by DHS to monitor child protection practice. Supervision is particularly important in the child protection setting due to the significant uncertainty that practitioners have to grapple with when they make decisions about the risk of harm to a child.

The unallocated cases measure (along with other indicators) was used by the Victorian Ombudsman to assess the effectiveness of statutory child protection services. The Ombudsman's reports are considered next.

These patterns of re-reporting and resubstantiation are examined in further detail in section 9.5 of this chapter in relation to capacity constraints affecting the provision of statutory services.

Figure 9.32 Children in child protection substantiations in 2009-10, by number of substantiations to date, Victoria



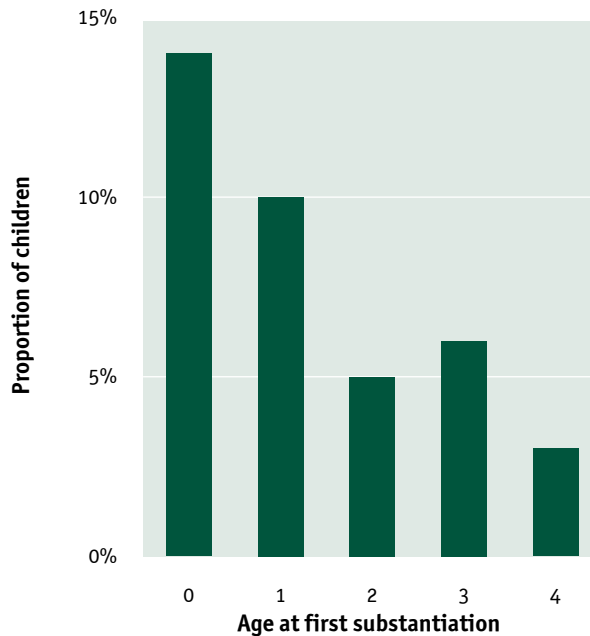
Source: Inquiry analysis of information provided by DHS

Table 9.3 Analysis of substantiated child abuse and neglect, by selected ages, Victoria, 2009-10

Age at time of substantiation in 2009-10	5	10	15
Number of children	316	301	348
% children with multiple substantiations	48%	48%	49%
% children with >3 substantiations	7%	15%	13%

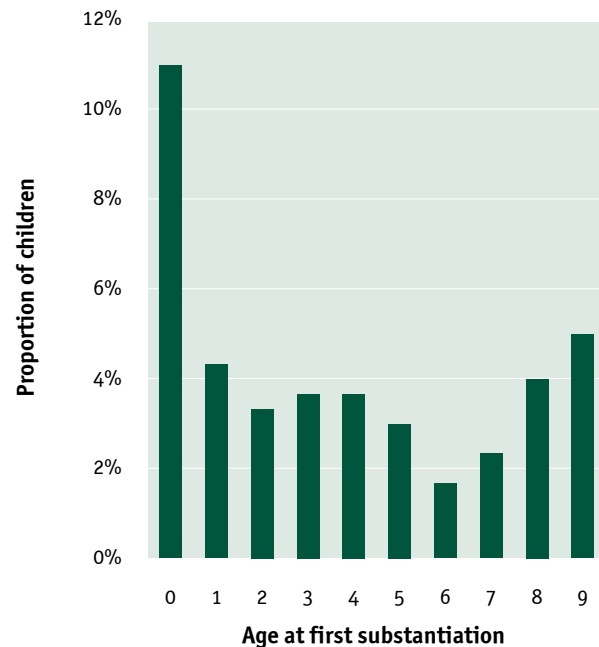
Source: Inquiry analysis of information provided by DHS

Figure 9.33 Five year old children with child protection substantiations in 2009–10 and prior substantiations, by age of first substantiation, Victoria



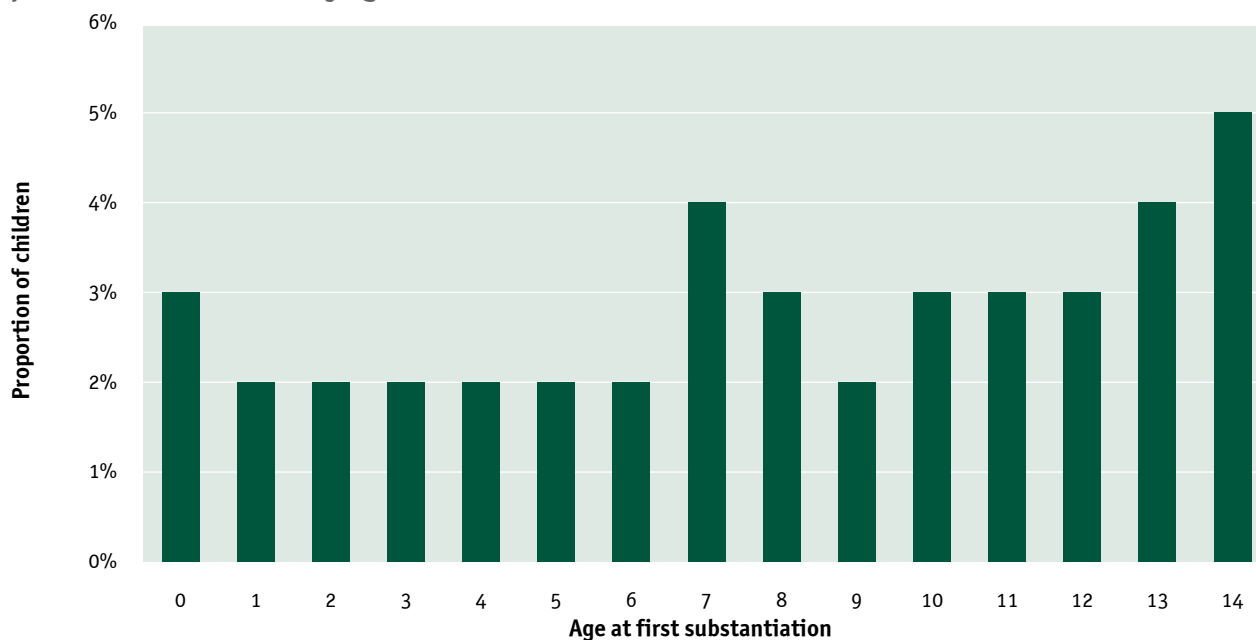
Source: Inquiry analysis of information provided by DHS

Figure 9.34 Ten year old children with child protection substantiations in 2009–10 and prior substantiations, by age of first substantiation, Victoria



Source: Inquiry analysis of information provided by DHS

Figure 9.35 Fifteen year old children with child protection substantiations in 2009–10 and prior substantiations, by age of first substantiation, Victoria



Source: Inquiry analysis of information provided by DHS

9.4.3 *Reports by the Victorian Ombudsman*

The Victorian Ombudsman's investigations into the system for protecting Victoria's vulnerable children are discussed in detail in Chapter 4. This section highlights the Ombudsman's key findings in relation to the performance of the child protection program.

In his 2009 report into the child protection program, the Ombudsman found that 'the system is struggling to meet its operational responsibilities' and that some regions in particular seemed to be operating under serious pressure (Victorian Ombudsman 2009, p. 9). The report highlighted a number of performance issues arising from the provision of statutory child protection services including:

- Resource constraints for DHS affecting the quality of services, for example, the timeliness of response to an allegation of abuse or neglect, or addressing cumulative harm caused to children and young people;
- The rate of unallocated cases where child protection practitioners are not allocated responsibility for addressing a vulnerable child or young person's needs, particularly in regions such as Gippsland;
- The threshold of harm for risk of abuse or neglect to children being applied variably across Victoria;
- Functionality problems surrounding the rollout of the CRIS information technology system; and
- Issues with the recruitment and retention of child protection practitioners resulting in vacancies and inexperienced staff (Victorian Ombudsman 2009, pp. 9-18).

The Ombudsman also commented on the size and complexity of DHS' responsibilities, querying the complex web of communication pathways created by lines of reporting from the level of a child protection practitioner to the Secretary (Victorian Ombudsman 2009, pp. 110-112).

In his 2011 report on statutory child protection services delivered in the Loddon Mallee region in Victoria, the Ombudsman made several findings about the efficacy of child protection intake, including:

- Failures to protect children at risk;
- The pursuit of numerical targets overshadowing the interests of children;
- A practice of providing the minimum possible response to child protection reports that can be justified; and
- Poor record-keeping.

The Ombudsman's findings suggest the number of investigations carried out by DHS should have increased in line with the increase in the number of reports received during 2010-11. The report reflects on the Ombudsman's previous report from 2009 and argues that independent scrutiny of the thresholds applied by DHS when deciding which reports to investigate should be present.

Other issues highlighted by the report include:

- Premature closing of cases with poorly documented risk assessment and reasons for the decision not to complete an investigation of a report;
- Inappropriate case allocation practices to staff on leave or whose normal duties should not have included being allocated cases (for example, specialist child protection practitioners, supervisors or managers); and
- The influence of using snapshot data at a point in time on case closure decisions and unallocated case trend data.

The Ombudsman expressed concern that higher thresholds for investigations may be applying more broadly in Victoria because the proportion of reports investigated was lower during 2010-11 than it was in 2009-10. The Ombudsman also noted that the number of repeat reports has increased across Victoria during the past two years. No further data as to the outcomes for those children re-investigated or re-substantiated was examined by the Ombudsman.

9.4.4 *Victorian Child Death Review Committee*

The role of the Victorian Child Death Review Committee (VCDRC) is described in Chapters 4 and Chapter 21. Chapter 4 also describes the extent to which child deaths in Victoria have involved children known to DHS statutory child protection services.

The VCDRC advised the Inquiry that practice and service delivery issues consistently identified in child death inquiry reports included:

- Problems with assessment, information gathering and analysis by child protection practitioners, including where information is not routinely being sought from important universal services; and
- The need for more effective communication and collaboration between child protection statutory services and other services including re-invigorating case conferencing as a basic working together mechanism (VCDRC submission, p. 23).

The VCDRC does not express an opinion about the factors leading to a child's death nor does it determine culpability. Responsibility for these matters rests with the State Coroner.

9.5 Statutory child protection services: major issues

Based on the Inquiry's analysis of the performance of the statutory child protection service and also drawing on the input received through submissions, there are three major issues that need to be addressed. These issues are:

- The question of whether statutory child protection services are sufficiently resourced to intervene when required to protect vulnerable children and young people, given:
 - the changing nature of child protection reports and increasing knowledge about the risk factors likely to give rise to child abuse and neglect;
 - the continuing rise in reports to statutory child protection services and expectations that these reports will be managed appropriately;
- The efficiency and effectiveness of child protection practice, encompassing a range of issues arising from re-reporting and resubstantiation trends but also recognising some children and families are clients of both statutory child protection services and family support services; and
- Once a child has been brought into the statutory child protection system, the need to improve stability in placements for vulnerable children and young people, to avoid causing further harm and trauma.

9.5.1 Statutory intervention capacity

While the Inquiry has recommended increasing the level of funding to meet the needs of Victoria's child protection system, it recognises that as with any other area of government service delivery, statutory child protection services will always be operating in an environment of resource constraints. Ideally, the amount of statutory child protection services provided would be directly tied to the prevalence of child abuse and neglect occurring in Victorian communities. However, in the real world in which Victoria's statutory child protection system operates, it is almost impossible to construct such an approach as there are no precise measures of the prevalence of child abuse and neglect. It is very difficult to determine likely future demand for statutory child protection services, particularly given the constantly changing views within society about what might constitute child abuse and neglect.

This dilemma is exacerbated because the increase in the number of child protection reports is not a direct representation of the increase in prevalence of child abuse or neglect. This is because reports today cover a much broader range of child and family

welfare and safety issues than they did previously (for example, the concept of cumulative harm was not necessarily recognised or understood in the past but is increasingly being identified as a particular risk factor for some children and young people). The expanded scope of reports reflects society's broadened understanding of vulnerability and what places a child at risk of harm. Advances in scientific knowledge about the impact of child development on brain functioning combined with legislative changes widening the grounds for statutory intervention have inevitably affected the nature of child protection reporting, and therefore the level of resources that Victoria needs to dedicate to its statutory child protection and related services.

As a result of these changes, the scope of a report to Victoria's statutory child protection authorities has progressively widened from covering emergency, episodic issues to also encompassing a broad range of issues faced by chronically vulnerable families. Such increased awareness of vulnerability and child abuse and neglect in our society has led to an increased willingness by professions and individuals to express concern about risks to a vulnerable child or young person's wellbeing by making a report to statutory child protection. As a result, Victoria's child protection intake now receives a significant number of reports each year. In 2011 the number of reports to Victoria's statutory child protection intake was around 55,000 and growing.

Many submissions commented on the growth in child protection reports (for example The Salvation Army submission, p. 22 and the Anglicare Victoria submission, p. 10).

The significant number of reports received by child protection intake has an inevitable impact on the nature and delivery of statutory services. To cope with this unpredictable, changing and increasing demand, significant resources within statutory child protection must inevitably be directed towards creating a sophisticated set of screening processes at intake to enable the best possible assessment of risk and a prioritisation of the increasing number of cases which are being brought to the attention of statutory child protection services. The inevitable consequence of the constant and significant increase in the number of reports is that the structure, focus, and allocation of resources within Victoria's statutory child protection services are increasingly being driven by the need to cope with assessments of this increasing number of reports. This means there is an inevitable reduction in focus on other vital functions such as prevention and early intervention with vulnerable children and their families.

Decision making for statutory intervention

Statutory child protection services must consider and assess every report that raises concerns about children and young people. This is the role of the intake team. In doing so, DHS considers the appropriate service response for each report and determines whether or not it has reached the threshold of risk of significant harm for a particular child that requires a statutory response and investigation. As can be seen from the outcomes of reports illustrated above at Table 9.1, the majority of these reports, when investigated by DHS, are not deemed to meet the current statutory threshold for further action by DHS, which is defined as 'of immediate risk to the harm or safety for a child'.

The formal statutory threshold that must be reached before a child protection practitioner can decide that some form of statutory intervention response is required is that there must be a risk of 'significant harm' to the child or young person who is the subject of the report (s. 162, CYF Act). The CYF Act requires that government will only use statutory investigatory powers to monitor parental capacity when it is absolutely necessary to ensure a child or young person's wellbeing and safety. If a report does not concern a risk of significant harm, then DHS either takes no action if this is appropriate, or refers the family concerned to a relevant support service if this is more appropriate.

Victoria's statutory child protection services, like those elsewhere, must therefore address an inherent tension arising from the broadened community view of what places a child at risk of significant harm:

They get criticised for not doing enough to protect some children, whilst at the same time being criticised for being too intrusive or not managing demand (Mansell et al. 2011, p. 2,076).

Comments made by submissions to the Inquiry illustrate this tension.

The CatholicCare submission argued that statutory child protection services are at times too focused on reducing the number of reports at the expense of undertaking sufficient investigations that could avert a later escalation. CatholicCare argued that the system should be broadened to encourage and promote help-seeking by parents to enable greater early intervention and prevention through non-statutory support (CatholicCare submission, pp. 9-10).

The Australian Childhood Foundation submission argued that the threshold of harm a child must suffer before statutory action is initiated is too high and that there was a decision-making culture that prioritises diverting reports away from statutory child protection when it is not appropriate to do so (pp. 1, 5).

Other submissions argued there is confusion over where reports should be directed and that there was a poor understanding of the differences between statutory and voluntary services, and which course was the most appropriate for different situations (FamilyCare, p. 12; Australian Childhood Foundation, p. 3).

The tension in the scope and direction of statutory child protection services is exacerbated by the very nature of the task of assessing risk in dynamic and fluid family situations. Even though a high-quality professional decision made by a highly qualified professional might determine that the probability of significant harm for a child in their birth family is low, low probability events, such as child deaths, do happen (Munro 2010, p. 21). Even with the most conservative decision making thresholds in place, child protection statutory services would not be able to prevent the death of every single vulnerable child or young person in society. Indeed, child deaths occur in families with no known history of child abuse or neglect.

A critical factor affecting DHS' decision-making practices about whether some form of intervention is required is the known occurrence of false-positive and false-negative results for protective risk assessment. 'False-positive' risk assessments occur when DHS, for a number of reasons, over-estimates the risk presenting for a particular child or young person and unnecessarily responds with statutory intervention when this is not required for a given family situation. A 'false-negative' assessment occurs when DHS under-estimates the risk presenting for a given report and fails to detect the risk of significant harm of abuse or neglect. As Munro has observed, changing decision-making practices with the objective of reducing false positive assessments will inevitably increase the rate of false negative assessments and vice versa, other things being equal (Munro 2010, p. 21). The two assessment errors are inextricably linked; if a low threshold has been set for intervention, then a high rate of false positives will occur. Conversely a high threshold for intervention will see a higher number of false negatives, or missed cases of significant risk (Munro 2010, p. 22).

Measures of effective statutory intervention

In addition to trying to design a statutory child protection system that has a sophisticated and effective method of determining the likely risk to a child of child abuse or neglect, it is important to determine if the statutory child protection system is effective in meeting its goals. In order to determine whether Victoria's statutory child protection service is meeting its goals and if it is constrained by insufficient capacity or resourcing, the performance of these services must be evaluated against a view, or value statement, as to what their objective is. As noted in Chapter 4 and captured by the Inquiry's Terms of Reference – the key objective of Victoria's system for protecting children is reducing the incidence and negative impact of child abuse and neglect.

The question of whether the right level of statutory child protection services are being provided to the Victorian community requires a judgment as to what is the most effective means of achieving this objective.

Assessing the performance of the statutory child protection system is a complex exercise. This is because of the inherent nature of statutory child protection services as an interconnected chain of activity flowing from intake through to investigation, protective intervention and assessment, protective orders and, ultimately, placement of children in out-of-home care. Resources and demand are distributed

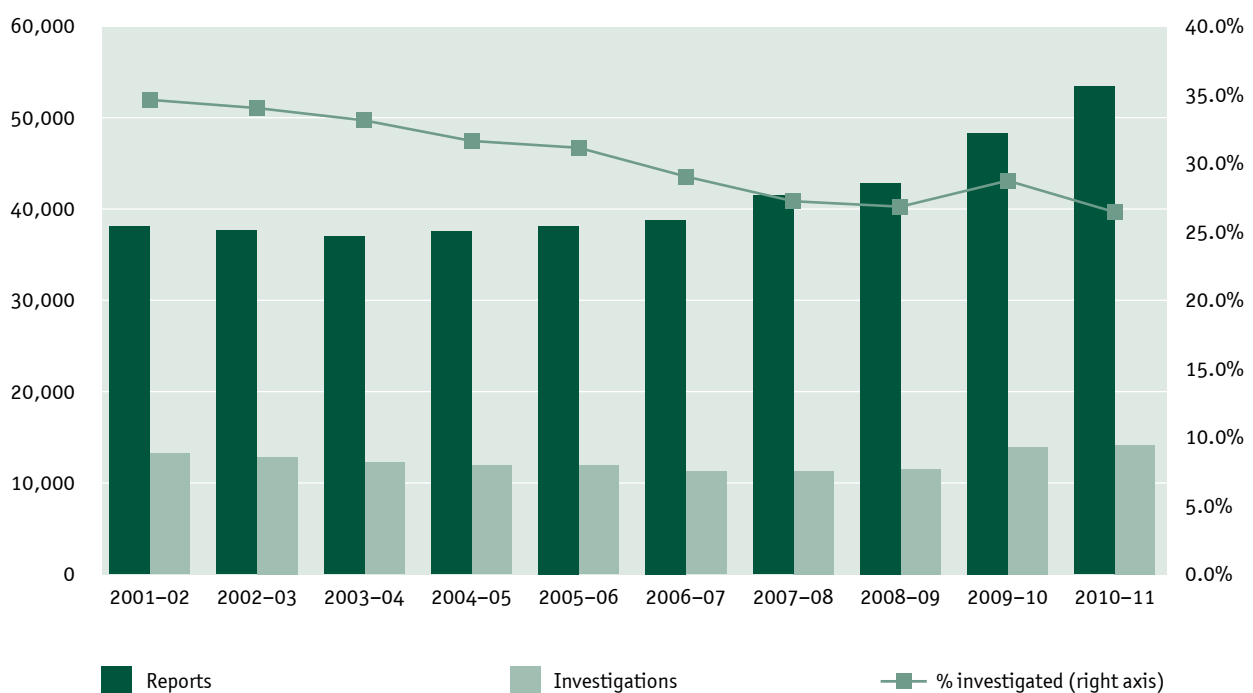
throughout this chain. Significantly, statutory child protection services on their own have only a limited ability to affect the fundamental underlying risk factors for child abuse and neglect.

However, even though it is difficult to assess the performance of statutory child protection systems, it is important that these assessments be done. The following data provides a partial picture of Victoria's statutory child protection systems, performance and capacity.

Proportion of investigations carried out on reports

As can be seen in Figure 9.36, while reports have risen, the proportion of investigation to reports has declined. The Ombudsman was particularly concerned about the proportion of investigations carried out in Loddon Mallee, arguing that the failure to increase the number of investigations in line with the number of reports received carried a significant risk that vulnerable children may be left in unsafe circumstances. The Ombudsman quoted the Secretary of DHS' advice in relation to implementation of his 2009 report: 'With a continued growth in reports, the investigation rate is likely to come under further pressure as the capacity of the child protection program to investigate reports is finite' (Victorian Ombudsman 2011d, pp. 24-25).

Figure 9.36 Child protection reports, investigations and investigation rate, Victoria, 2001-02 to 2010-11



Source: Inquiry analysis of information provided by DHS

Note: Investigation rate refers to the percentage of reports investigated

Staffing, case carrying loads and unallocated cases

The number of child protection practitioners has increased in recent years, although the proportion of case-carrying workers has declined slightly (see Figure 9.37). This could be possible due to the increase in staffing numbers mainly affecting CPW1s and specialist workers who do not normally carry cases.

Although there are now 20 per cent more reports per child protection practitioner than there were five years ago, the number of annual investigations per worker is relatively unchanged and average case loads have declined since 2009 (see Figure 9.38).

Since 2009, the variation in caseloads by region appears to be reducing. Also since 2009, the number of unallocated cases has more than halved and regional variance has dramatically decreased (see Figure 9.39).

Evidence of changes in the nature and effort involved for cases is apparent from the change in the number of open cases being dealt with by child protection practitioners. There were 41 per cent more open cases in 2010-11 than there were in 2005-06.

In addition, analysis of children who were the subject of a report in 2009-10 reveals that, in relation to time spent by cases in the different phases:

- While a large number of cases proceed from report to protective intervention and assessment within a week, 50 per cent take longer than 31 days and 20 per cent take more than 90 days; and
- Just under half of cases remained in the protective intervention and assessment phase after 150 days of the date of the report.

Complexity of cases receiving statutory child protection services

In summary, the data on statutory activity indicates that:

- While reports have increased over time, the rate of investigations conducted has not (Figure 9.36);
- Average caseloads have decreased for staff (Figure 9.38);
- Unallocated cases have decreased (Figure 9.39); and
- The total number of open cases has increased (Figure 9.40).

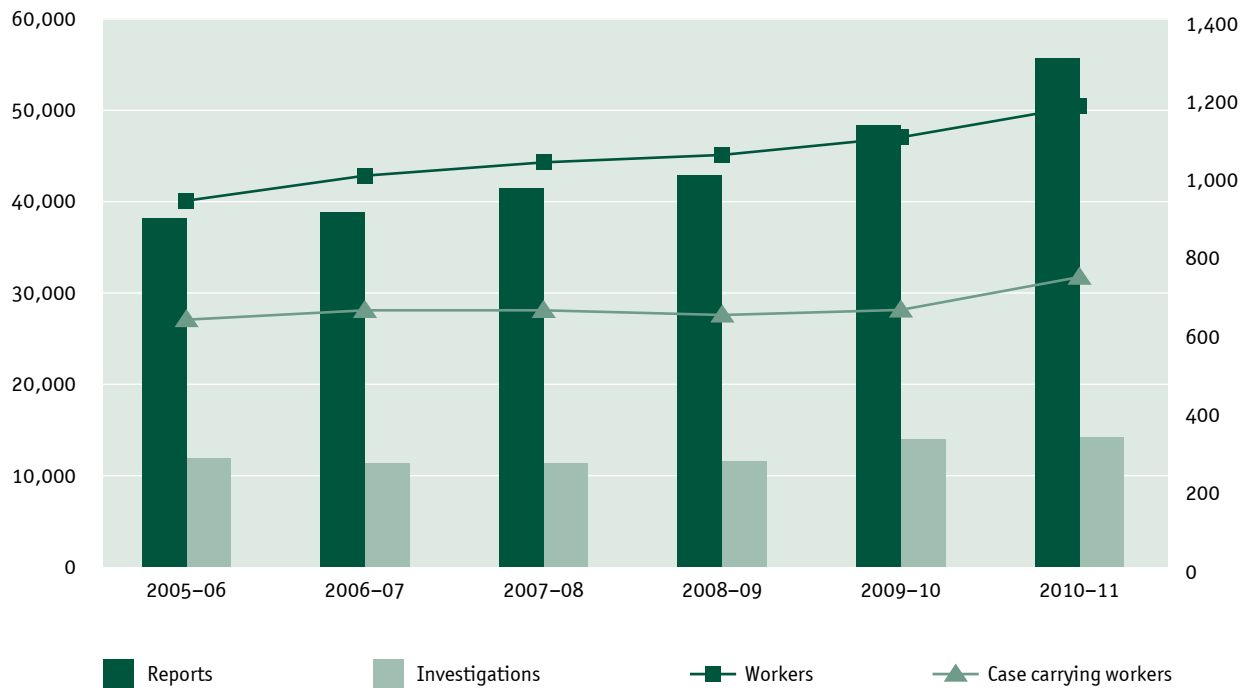
The Inquiry is concerned that statutory child protection services should be undertaking an appropriate rate of investigations based on the best interests of children and their safety. On the face of it, it could be assumed that an increase in reports would lead to an increased rate of investigations. However, the appropriateness of investigations undertaken is inextricably linked to an assessment of the circumstances of each child or young person. To arrive at a view about the appropriate level of investigations, the Inquiry has sought to understand why DHS decides to investigate some cases and not others. Two primary drivers for statutory child protection investigation decision making are case complexity and workload pressures.

Significant data limitations have meant that the Inquiry is unable to arrive at a precise view about the complexity of statutory child protection cases. Although there is rich case material on the CRIS database, DHS was unable to extract client complexity material for the Inquiry.

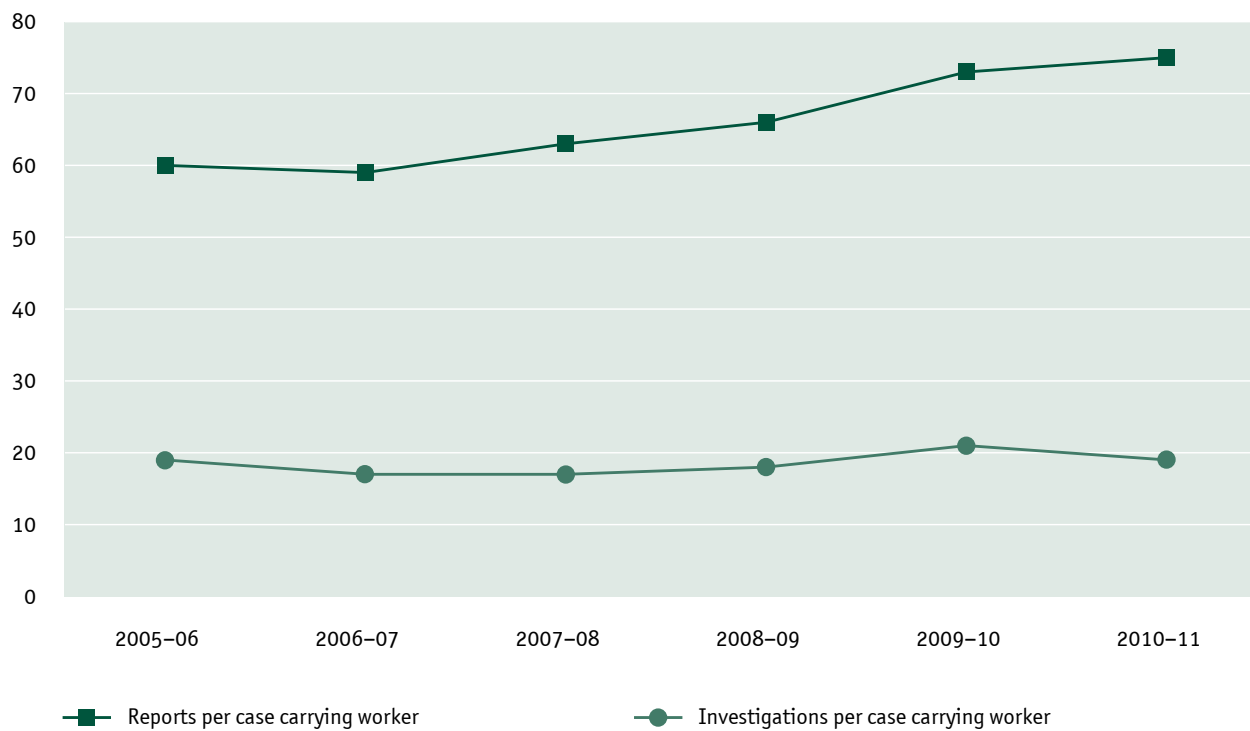
In terms of the workload demand pressures on investigation staff and strategies used by DHS to manage these, the Inquiry has found these difficult to assess due to the interconnected nature of activity across the statutory intervention phases. No data was available for the Inquiry to assess the relative effectiveness of allocation of resourcing effort across the various statutory intervention phases. In future, this would require mapping of staff effort across the phases. Another critical input is also a greater understanding of demand pressures across the statutory child protection system. Demand pressures and implications for resourcing are considered in more detail in Chapter 19.

In addition to these significant data limitations, there are a number of additional factors to be taken into account that influence the capacity of statutory child protection services. These include, for example, the length of time required to complete court processes authorising intervention (see Chapter 15). Another major factor contributing to the complexity of caseloads is the social infrastructure present in the various communities where vulnerable children and young people reside. Similarly, levels of staffing experience and competence have an effect on capacity.

The Inquiry considers that these data gaps and capacity issues must be investigated urgently by DHS in order to inform future analysis and improvements of statutory child protection services.

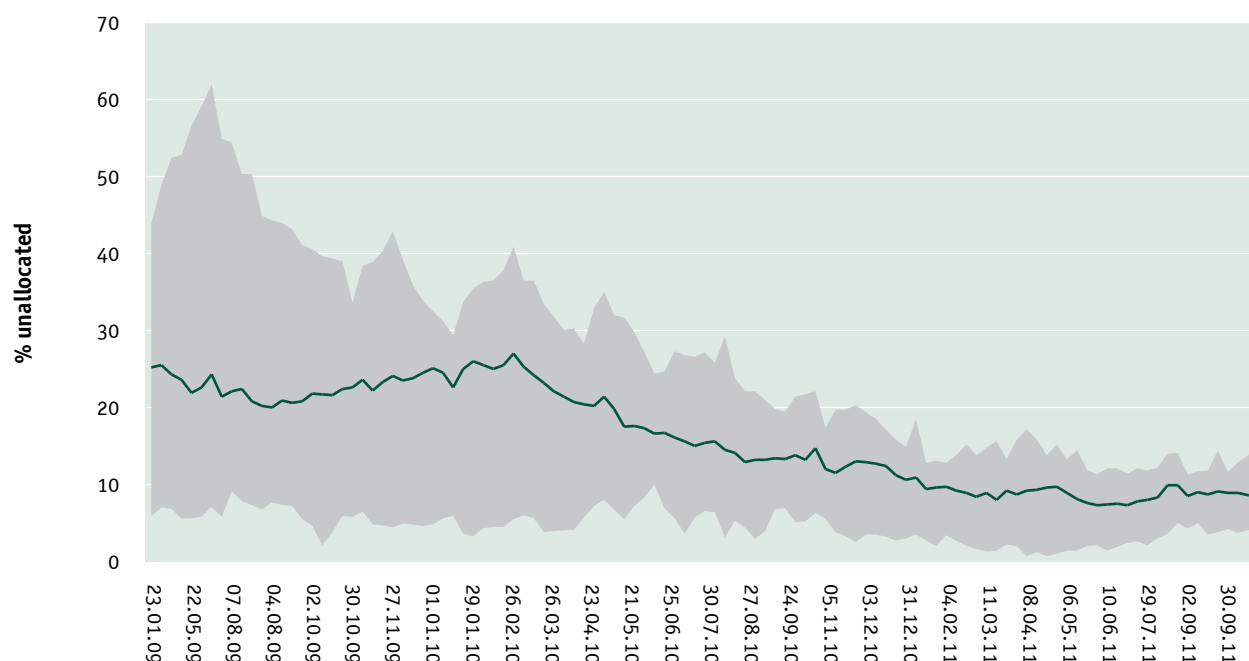
Figure 9.37 Child protection reports, investigations and child protection workforce, Victoria, 2005-06 to 2010-11

Source: Inquiry analysis of information provided by DHS

Figure 9.38 Child protection reports and investigations per case-carrying child protection worker, Victoria, 2005-06 to 2010-11

Source: Inquiry analysis of information provided by DHS

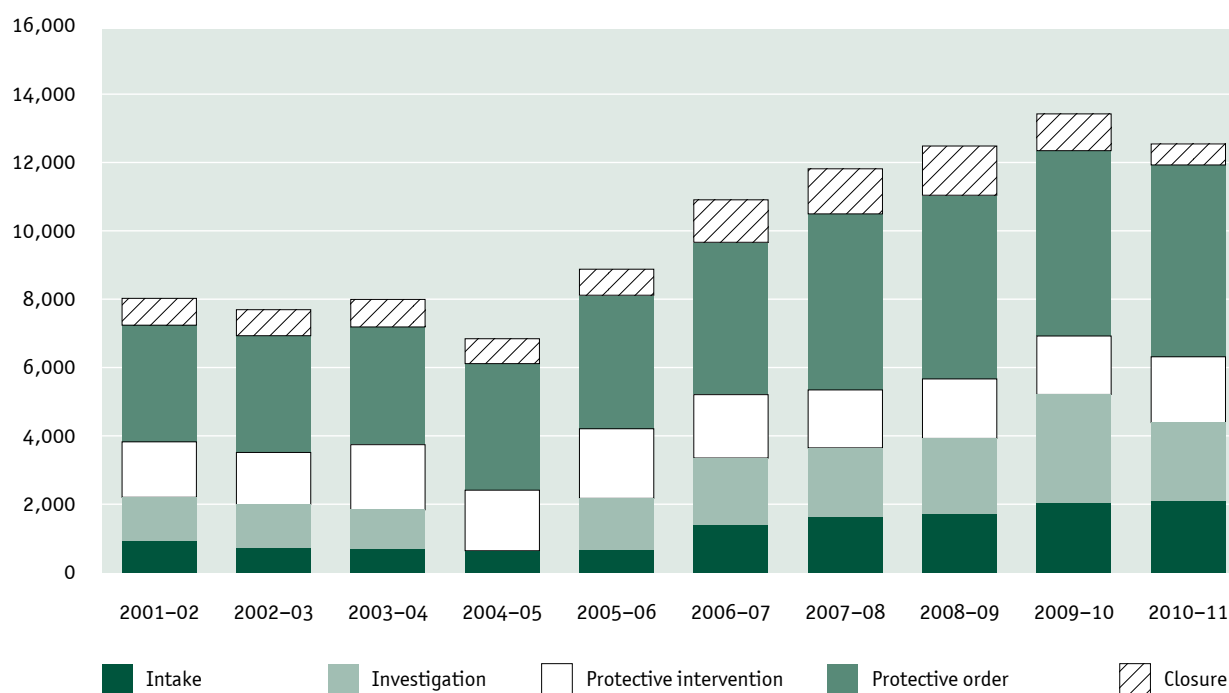
Figure 9.39 Child protection unallocated cases percentage, Victoria and regional variation, January 2009 to September 2011



Source: Inquiry analysis of information provided by DHS (no data available prior to 2009)

Note: Grey shaded area shows the difference between the DHS regions with the highest lowest unallocated cases percentage.

Figure 9.40 Child protection cases, by statutory child protection phase, Victoria, 2001-02 to 2010-11



Source: Inquiry analysis of information provided by DHS

The most effective service response for reducing the incidence of child abuse and neglect

The role of increased statutory intervention as a mechanism to reduce the incidence of child abuse and neglect must be considered in the context of government's overall service response to vulnerability. There may be a detrimental impact for families and children that arises from being unnecessarily brought into statutory intervention processes, that is, a false positive. Unnecessary government intervention runs the risk of damaging relationships within already vulnerable families (Mansell et al. 2011, p. 2,078; Higgins & Katz 2008, p. 44). As Mansell observes, concerns exist that highly coercive powers to separate families might be undertaken with little or no consultation, lead to worse outcomes and target over-represented, marginalised communities such as Indigenous populations (Mansell et al. 2011, p. 2,077).

Victoria's statutory child protection services must have the capability to respond effectively in a timely manner to soundly made reports of possible child abuse and neglect. However, a key question the Inquiry is concerned with, is whether an increase in investigations and substantiations, by itself, is the most effective means of achieving the government objective of protecting vulnerable children and reducing the incidence of child abuse and neglect.

The threshold point at which statutory child protection practitioners decide to intervene in a family is a judgment made by policy makers and practitioners about the scope of what constitutes child abuse and neglect, and, as Munro has observed, this is sometimes influenced by media coverage of mistakes made by statutory child protection systems and the public's response to those mistakes (Munro 2010, p. 23). However, as discussed above, if a society becomes 'risk averse' in relation to its child protection system, it is important to note the impact of increasing the number of false-negative risk assessments, or over-estimation of risk because of the serious consequences for a child if they are unnecessarily placed in the statutory child protection system because of a misdiagnosis.

The best measure of the performance of a statutory child protection service should be based on the outcomes for those children receiving statutory child protection services. These outcomes for children should inform any consideration of the question of capacity and the resources required to sustain the system. The primary available data for assessing the effectiveness and outcomes for children and young people from statutory intervention, as discussed above, comprises the re-presentation rates of

vulnerable children who, despite an initial provision of statutory child protection services, continue to require additional statutory intervention at subsequent stages throughout their life.

The data presented, particularly in relation to resubstantiation trends indicates that outcomes are generally poor for those children provided with statutory child protection services because their chances of return to the statutory system are likely. In addition, outcomes for children and young people in out-of-home care are also poor and this is examined further in Chapters 10 and 11.

Such evidence demonstrates that Victoria's statutory child protection services are not effective at addressing the fundamental causes of child abuse and neglect. This is particularly persuasive when the major risk factors for child abuse and neglect are considered, such as alcohol and drug misuse, mental health and so on. These are areas of policy and practice that statutory child protection services are neither resourced nor tasked to provide.

The Inquiry considers that statutory child protection services are likely to be most effective when they are balanced with other services for children, young people and their families that are designed to reduce the vulnerability of Victoria's children and young people.

9.5.2 *The efficiency and effectiveness of child protection practice*

A number of submissions suggested to the Inquiry that the approaches currently adopted by statutory child protection services to assess and assist vulnerable children and young people could be significantly improved.

This section discusses issues that cover several areas of statutory child protection practice:

- Statutory child protection intake arrangements;
- Opportunities to use differentiated or customised approaches for providing statutory services;
- The concept of cumulative harm and how it has been applied in practice;
- The way statutory child protection services assess and plan for a child's needs including the task of collaborating or integrating service delivery with other agencies and departments;
- Improving case management practices;
- Managing risk and supporting practitioners;
- Workforce retention and professional development;
- Information communication technology (ICT) systems to support practice; and
- Trust and public confidence.

Statutory child protection intake arrangements

In order to improve the way DHS handles and refers reports about vulnerable children, a major system reform to the intake arrangements is required over time that more clearly specifies the respective roles and responsibilities of the available service responses to child abuse and neglect.

Many families and children do not currently receive any statutory child protection services because the level of risk, as determined by DHS, is not deemed to have reached the threshold required for statutory intervention. The Inquiry considers, however, that these reports are about vulnerable children and families with a wide range of needs. Statutory child protection intake arrangements need to connect these vulnerable families concerned in these reports more effectively to the agencies and CSOs equipped to meet the child and their family's needs. Statutory child protection intake does not function as an effective gateway to the wide range of family support and other services required to address vulnerability. Changes are required to intake arrangements that recognise and align the role of statutory services as part of a broadened service response across government that protects vulnerable children and their families. Intake arrangements can be better calibrated to ensure vulnerable children, where it is in their best interests, receive priority assistance from prevention and early intervention initiatives (in particular, alcohol and drug abuse, family violence, mental health and disability services).

The Inquiry's vision is for all the components of statutory intake and family support services to be working in unison to address the needs of vulnerable children before statutory child protection intervention is needed. The Inquiry's aim is for families to receive effective earlier intervention that proactively addresses risk factors such as drug or alcohol misuse. It is important to note, however, that improving the efficacy of referrals from statutory child protection to child and family support services can be expected to dramatically increase demand for voluntary community-based services for assistance and support for vulnerable families.

As discussed in Chapter 8 and also in Chapter 19 on funding, improving access to early intervention services will require a significant investment in the capacity of voluntary family, child and adult specialist support services. The progressive widening of the range of services available to children and their families anticipated through expansion of the proposed Vulnerable Child and Family Service Networks, will require increased, targeted investment to ensure access is available to those services.

Adopting a clearer policy position on the objectives of statutory child protection services requires a paradigm shift, not only in the way DHS sees its role, but also to the way that other departments, agencies and other family and adult specialist support services see their role as part of a whole-of-government response to vulnerable children and young people.

The Inquiry has expressed its vision for a more effective governance structure for delivering voluntary support services to vulnerable children and families through changes to the Child FIRST model in Chapter 8. Following these reforms, the introduction of a broadened service system, Vulnerable Child and Family Service Networks (Recommendation 17), could deliver an increased range of services to vulnerable families aimed at improving family functioning.

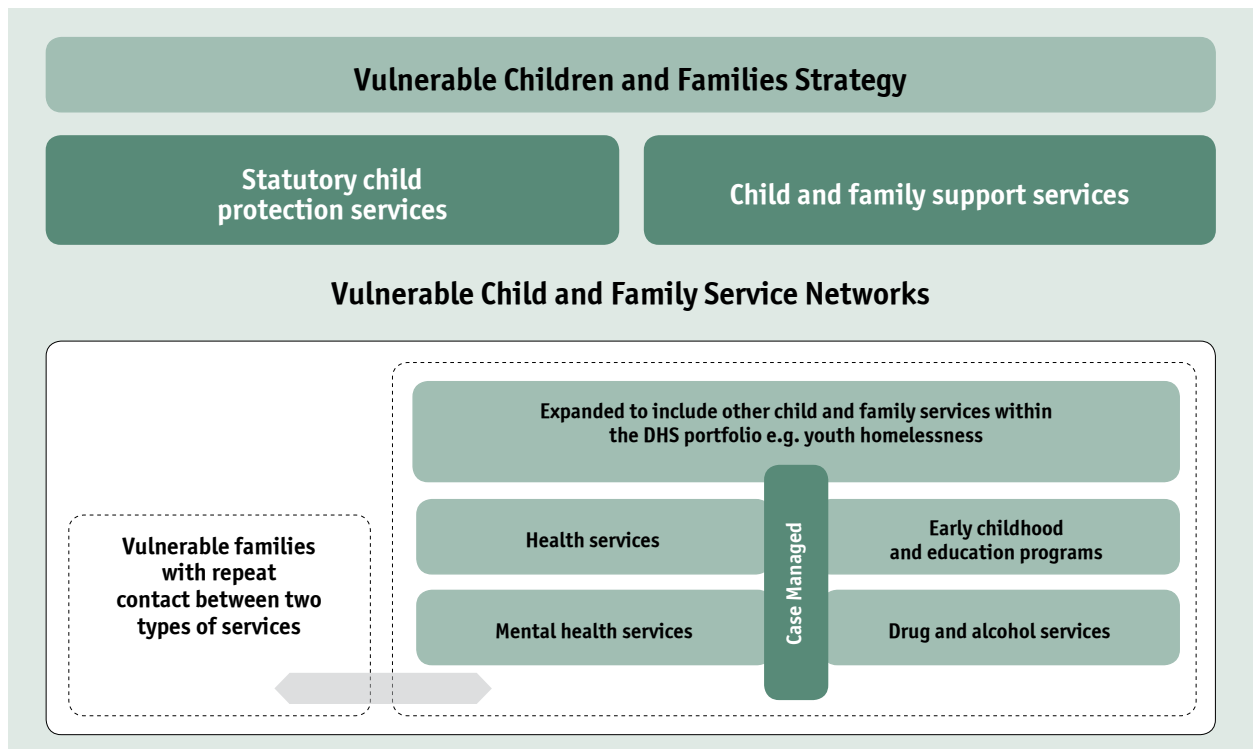
As can be seen from the nature of the proposed whole-of-government Vulnerable Children and Families Strategy (Recommendation 2), the Inquiry's vision for the future emphasises that statutory child protection services are part of and not separate from, the overall government and community response to child abuse and neglect (see Figure 9.41).

Over time and following the phased implementation of broader Vulnerable Child and Family Service Networks, it is envisaged that statutory child protection services could begin to be seen within the context of a broader service response, which would better recognise the interconnections between families experiencing chronic vulnerability and families that require statutory intervention. This also orients the range of possible service responses to one that is more capable of addressing a broader range of child and family need.

Accordingly it is important to consider changes to intake arrangements to support an evolved and broadened service response to child abuse and neglect.

The Inquiry received several submissions arguing for a strengthened and expanded partnership between government and the community sector in child protection intervention. In particular, the joint submission from Anglicare Victoria, Berry Street, MacKillop Family Services, The Salvation Army, the Victorian Aboriginal Child Care Agency and the Centre for Excellence in Child and Family Welfare (Joint CSO submission) proposed a new protection and care system where current statutory services would have an increased capacity to work with CSOs (Joint CSO submission, p. 9). This proposal argued for more collaborative arrangements recognising that government and the community sector share responsibility for achieving better outcomes for vulnerable children and young people across Victoria (Joint CSO submission, p. 10). Chapter 17 examines the appropriate relationship between governments and CSOs in more detail.

Figure 9.41 Vulnerable Children and Families Strategy and the role of statutory child protection services



Source: Inquiry analysis

Co-location of intake arrangements

The Joint CSO submission proposed co-locating child protection intake with the community services sector, arguing that this would improve the timeliness of decisions and responses and strengthen transfers of knowledge and skill between statutory child protection practitioners and CSOs. It also argued to improve the quality of decisions made as they would be made with more direct contact with those providing family support services to the vulnerable families involved. Anglicare Victoria's submission strongly supported the existing community-based child protection practitioners and argued that more should be based in high-demand Child FIRST sites across Victoria to facilitate collaboration and advice about engaging families with complex needs and ensuring timely statutory intervention where a child is at risk of significant harm (Anglicare Victoria submission, p. 18).

The Children's Protection Society submission also argued for greater community referral points to reduce service demand on statutory child protection services (Children's Protection Society submission, p. 32).

In addition to intake, the Joint CSO submission proposed co-locating child protection practitioners more broadly throughout local CSOs to provide secondary consultation services, carry out investigations and casework (for example co-locating

DHS specialist infant protective practitioners with maternal and child health services). This proposal would co-locate statutory child protection services with family and child support services because both organisations share the same clients to some extent.

The Joint CSO submission argued that many benefits would flow from co-locating child protection practitioners, including more timely, coordinated and effective service responses, with a focus on resilience and capacity building for vulnerable families. Additionally, this was expected to divert families from statutory services and enable identification and management of risk at an earlier point. It was argued that this environment would contribute to a more stable workforce, as it would provide more satisfying work for both child protection practitioners and CSO workers (Joint CSO submission, pp. 35-36; Anglicare Victoria submission, p. 19).

Co-location of intake arrangements recognises that the group of vulnerable children who are the subject of reports to DHS are not a dramatically different group of children from those who are referred to child and family support services. Bringing intake decisions about these two types of services together provides a better holistic picture to government, of both the prevalence of vulnerability but also a means of assessing the effectiveness of the service responses provided or funded.

The Inquiry considers that co-locating intake processes so that DHS statutory child protection practitioners sit physically alongside CSO Child FIRST intake workers would drive greater collaboration and knowledge sharing about protective risk assessment. Such a change would evolve the current community-based child protection practitioner function to co-locating intake teams on an area basis. Separate lines of accountability would remain in place, with DHS statutory intake workers reporting to the Secretary of DHS, and Child FIRST intake officers working within the strengthened governance arrangements for Child FIRST recommended in Chapter 8.

The Inquiry considers that co-location of intake is a foundation reform that must be successfully implemented, through a pilot approach, and evaluated before any further changes to intake could be contemplated. Although the Inquiry sets out below a future vision for further reforms to intake arrangements, a number of serious risks and challenges are presented by these changes that must be considered carefully and addressed before any reforms could be trialled in the future.

A vision for consolidated intake

The Inquiry considers that a future vision for statutory child protection intake would involve a consolidated approach to intake, which would combine decision making about reports. A consolidated intake approach would have as its goal a well-respected, area-based single entry point for a broad range of services. A single entry point would be responsible for connecting members of the surrounding community to government or community services that respond to the prevalence of vulnerability and priority risk factors for child abuse and neglect. One of these possible service responses would include statutory intervention where it is required to ensure a child's safety, but another possible service response readily available is a range of support services designed to meet the needs of a vulnerable child and his or her family before statutory intervention is required.

The area-based entry point would involve experienced DHS and CSO staff working jointly, in a logical extension of co-located intake. As indicated in the Inquiry's vision for a Vulnerable Child and Family Services Network in Recommendation 17, this entry point would represent a broadened spectrum of service responses.

Matters that must be addressed before the Inquiry's vision could be realised

Continued demand pressures

As noted above, the Inquiry's recommendations require a significant increased investment in the funding to child and family support services in order for these services to be able to respond adequately to the anticipated increase in demand. The Inquiry's vision is to connect families involved in child protection reports that currently receive little effective service response from DHS (the 35,000 or so reports that receive advice, information or no action) to a more effective response that minimises the likelihood of subsequent intervention. A better picture of demand is expected to result from consolidated intake arrangements that will better equip government to forecast future funding requirements and assess the efficacy of the services it funds and provides.

The need for continued self-referral to support services

Moving to a consolidated area-based intake point aligns with the Inquiry's vision that statutory child protection services are part of and not separate to government's efforts to tackle the prevalence and impact of child abuse and neglect. As such a single entry point would eventually become a first port of call for families seeking help. Over time, a consolidated intake point would need to become known as a broad entry point to a wide range of child, family and specialist adult support services that are closely linked to statutory child protection.

Self-referrals to services must not be compromised by a consolidated entry point and, similarly, service providers should continue to be able to refer families directly to voluntary family services. Such referral behaviour should continue to occur, albeit with the benefits seen with the Child FIRST reforms that have enabled greater tracking of trends and outcomes data for vulnerable children and families.

Avoiding duplication and additional complexity

The Inquiry's vision is to simplify the burden of navigation for vulnerable children and their families requiring different types of services ranging from family support to specialist child and adult services. It should be easier for children and families to be connected to local services in their communities. A common assessment process by the broader range of services will become more important as the Vulnerable Child and Family Services Network evolves over time.

It is critical, however, that any future reforms do not carry the unanticipated consequences of establishing additional intake processes or gatekeepers. The second phase of statutory child protection, investigation, would need to remain in DHS and as it currently operates and not function as a secondary intake process. Similarly CSOs delivering child, family and specialist adult support services should not be carrying out secondary intake decision making except in the most exceptional of circumstances. Likewise, existing arrangements for referring suspected criminal acts to Victoria Police should not be affected by these reforms.

Matter for attention 6

The Inquiry draws attention to the need for any future reforms towards consolidated intake arrangements to avoid establishing secondary intake decision-making, including at both the second investigation phase of statutory child protection services or by community service organisations delivering child, family and specialist adult support services, except in the most exceptional of circumstances.

Separating intake from investigation

The need to overcome barriers or challenges caused by the physical separation of intake practitioners from statutory intervention practitioners must be actively planned for and managed. Communication protocols, face-to-face handover requirements and supporting ICT tools will need to be developed. Outcomes from the recommended piloting of co-location intake arrangements will provide valuable information and experience that should be used by DHS to manage the challenge of physical separation of intake from investigation.

Recommendation 19

Following adoption of the Child FIRST governance changes and using a piloted approach, intake functions carried out by the Department of Human Services and by Child FIRST should be physically co-located on an area basis throughout Victoria. Statutory child protection intake should remain a separate process to child and family support services intake, but there should be an increased focus, particularly with common clients, on improving collaboration between statutory child protection and family support services and greater joint decision making about risks presenting to vulnerable children and young people.

Following implementation and evaluation of co-located intake throughout Victoria, and provided the key challenges and risks have been addressed appropriately, the Department of Human Services should aim to move towards a consolidated intake model where Child FIRST and statutory child protection intake processes are combined.

Opportunities to use differentiated or customised services

For some vulnerable families, the level of risk presenting to a child may be dynamic, or episode driven. From time to time, a family may move between only requiring broader family support services or when particular incidents or events occur, statutory intervention may be required to address the risk of harm for a child or young person.

The increasing complexity of vulnerability indicates that different approaches are required to improve outcomes for different client groups, based on the types of problems present in those families.

Some piloting of more customised or differential responses to families' needs has been trialled by DHS and other jurisdictions, and initial evidence indicates that these approaches could improve outcomes for vulnerable children and young people. Other approaches were specifically endorsed in submissions to the Inquiry as areas where advances in knowledge about therapeutic approaches should be applied.

Differentiated pathways use specialist and therapeutic service streams that are customised to the particular problems experienced by vulnerable children and young people. Differentiated pathways provide an opportunity to improve the quality of assessments provided to children and young people through a clearer understanding of the objectives of services for particular client groups. Adopting more differentiated pathways offers greater opportunities for CSOs and DHS to work more closely together to support these vulnerable families.

The Inquiry considers that two pathways in particular merit immediate implementation of a differentiated service response by DHS; these cover first-time contacts and victims of alleged sexual abuse. The first-time contacts pathway refers to cases where a vulnerable child and his or her family is first brought into contact with statutory child protection services. DHS could adopt an intensive approach with these children and families, with the objective of diverting the family from any future statutory involvement. This would involve convening intensive family meetings, strengthening links to family services and persistent follow-up of referrals so that problems are addressed earlier.

DHS has trialled this approach in the Eastern Metropolitan region with some signs of success (KPMG 2011c, pp. 2-5, 10). A focus on families with young children (such as children under five years of age) would be appropriate to develop this pathway.

Adopting a differentiated pathway for suspected child sexual abuse cases would strengthen current responses provided by DHS and the broader system for protecting children. Submissions pointed to low levels of substantiations and prosecutions (Powell & Snow, p. 3) and argued that DHS needed to be more proactive and prevention focused with respect to suspected child sexual assault cases (Children's Protection Society, p. 37).

The Inquiry considers that Multidisciplinary Centres (MDCs) are more sensitive to the needs of a child or young person allegedly subjected to sexual abuse because of the specialised training and co-location of support services, Victoria Police and DHS. Victoria Police and DHS have trialled this approach in Frankston and Mildura and submissions were supportive of these (CASA Forum, p. 9, Royal Children's Hospital, p. 12; Ms Wilson, Warrnambool Public Sitting). The Inquiry visited MDCs in Mildura and Frankston and was impressed by their operation, effectiveness and potential. Unmet demand for sexual assault support services and the prosecution of child sexual abuse is discussed in further detail in terms of the laws that protect children in Chapter 14 and MDCs are discussed further in Chapter 20.

The Inquiry has identified two additional pathways that require further collaboration and planning between DHS and CSOs before they can be implemented. These pathways would customise the service response for repeated contact families and families experiencing chronic and entrenched vulnerability. Ultimately adopting these pathways could lead to more contracting out of case management by DHS to CSOs.

Repeated contact families refers to those children and their families with high vulnerability who struggle to engage successfully with available support services. They are referred between and come into repeated contact with both statutory child protection services and child and family support services delivered by CSOs. Whether or not the family is involved with the statutory system is triggered by events or crises that move the level of risk from a wellbeing concern to a protective concern.

Adopting a repeated contact families pathway would lead to greater joint case management of these families between DHS and CSOs during the protective intervention and assessment phase. DHS would also increasingly consider contracting out pre-court case management responsibility to CSOs.

The Inquiry considers that different approaches need to be developed for cases where serious abuse or neglect have occurred with significant previous statutory child protection involvement including where older siblings in a family have been removed and placed in out-of-home care. DHS needs to adopt an approach that provides greater stability for vulnerable children who have experienced significant abuse and neglect, and for whom reunification with their birth family is unlikely to be successful. Barriers to permanent care should be addressed through this pathway.

Adopting a differentiated pathways approach for assessing and working with vulnerable families is critical for building a more sophisticated performance indicator framework that, over time, provides a better picture of how the statutory service system is performing against its objectives. Performance indicators to measure outcomes for the differentiated approach would include decreases in re-reporting and resubstantiation rates. In relation to sexual assault victims, the performance measures could include improved experiences for victims, greater prosecution rates when appropriate, greater stability for children with their protective parent and other improved outcomes. In relation to repeated contact families, an increase in the successful take-up of support service could measure the effectiveness of the statutory response.

Recommendation 20

The Department of Human Services should introduce differentiated pathways as part of the statutory child protection response, with some increased case management by community service organisations.

The two pathways that should be adopted immediately should involve first-time contact families and the use of multidisciplinary centres to respond to suspected child sexual abuse victims. Following collaboration between the Department of Human Services and key stakeholders, two additional pathways should be adopted to address the needs of families that have repeated contact with the Department of Human Services and families experiencing chronic and entrenched vulnerability.

Cumulative harm: a different type of abuse

Advances in child development knowledge have driven greater awareness of the significant harm that can be caused to a child through ongoing exposure, to lower levels of abuse and neglect over time (Bromfield & Miller 2007, p. 2; Higgins & Katz 2008, p. 44). The Take Two Partnership submission argued that the 2005 inclusion of cumulative harm as a grounds for intervention was widely considered an important and positive step (p. 4).

The notion of cumulative harm exposes the tensions that exist between the previous characterisation of statutory child protection services as designed to intervene only in emergency situations when there is a significant risk of harm to a child, and its present day, broadened responsibilities that involve longer term involvement with chronically vulnerable families that periodically experience crisis events.

The Children's Protection Society submission argued that difficulties pursuing cases of emotional abuse and cumulative harm as grounds of abuse might be because Victoria's system for protecting children remains event and crisis focused (pp. 32-33).

The primary targeting of statutory child protection services on children considered to be at the highest risk (with an emphasis on those children suffering physical and sexual abuse) was argued to reduce the capacity for effective early intervention as well as 'losing sight of the cases where children are still at risk of cumulative harm' (CatholicCare submission, p. 9).

Submissions argued that problems applying cumulative harm as grounds for protection arose from different interpretations and practical applications of the concept (Take Two Partnership, p. 4). FamilyCare argued that there are problems in regional courts' interpretation of cumulative harm (FamilyCare submission, p. 17). The Children's Court, however, argued that the difficulties arise instead from DHS' focus on crisis events, rather than a family's history (Children's Court submission no. 2, p. 26).

Identifying and responding to cumulative harm requires more long-term interactions with a vulnerable child or young person in contrast to a once-off intervention. It also involves multiple reports of a low-level concern or abuse. Anglicare Victoria argued that developing skills in co-working cases between family services and child protection practitioners would enable intervention that is based on an assessment of both current and past harm (Anglicare Victoria submission, p. 16).

An individual submitter, Ms Johns, suggested more public and professional education was required by DHS to promote a greater understanding of cumulative harm among practitioners of health and welfare disciplines (Ms Johns submission, p. 2).

Further comments are made about the need to clarify the operation of cumulative harm in practice in Chapter 14, in relation to strengthening the law.

Assessing and planning for a child or young person's needs

Submissions to the Inquiry raised concerns about the quality and efficacy of case assessments, planning and the capacity of statutory child protection services to collaborate and integrate the services required to support a vulnerable family to care for their child safely.

Berry Street argued that there is a need to review, simplify and integrate the overlapping case planning and client information management and monitoring systems.

At present, the system is literally awash with well intended but overlapping requirements for the development and completion of plans for individual children and young people (Berry Street submission, p. 32).

St Luke's Anglicare argued that families find the child protection and wider service system complicated, bewildering and confusing, caused by the different services plans, assessments and referral tools developed for (not with) families by statutory services and the wider service system (St Luke's Anglicare submission, p. 15).

The FamilyCare submission stressed the difficulties inherent in undertaking child protection work and noted that sweeping criticisms of DHS and its staff coupled with sensationalistic media reporting was unfair and often inaccurate. With these caveats in mind, however, FamilyCare argued that obtaining vital input or feedback from child protection practitioners was too slow, intermittent or unreliable. Communication challenges with DHS were found to undermine opportunities for effective interaction and collaboration with other service providers in relation to planning and care (FamilyCare submission, p. 12).

The VCDRC submission argued that statutory child protection services and service partners need to put a higher value on reciprocal communication and constructive challenge of divergent assessments in order to build shared understandings as the basis of working together (p. 24).

DHS managers suggested case planning could be simplified and proposed the Looking After Children framework should be used as the building block for developing a single plan (Inquiry workforce consultations).

Collaboration across service systems

Many submissions referred to the need for a comprehensive and integrated service response that addresses not only the protective concerns for children or young people, but that also covers mental health, education, alcohol and drug use and other issues. The Take Two Partnership submission argued that a major problem with the adult and child service system is the continuously 'siloed service systems' that fail to address the complex needs of vulnerable children and families (p. 1).

The Child Safety Commissioner argued that 'it is clear that "silos" within and between departments and professional groups and services still exist'. The Child Safety Commissioner noted that case reviews had revealed many examples of inadequate collaboration and coordination between services and professionals, including a lack of clarity regarding roles and responsibilities, inadequate communication and no case conferencing or shared understanding about case directions (Office of the Child Safety Commissioner submission, p. 3).

In relation to family violence and disability services in particular, greater clarity is required as to which service system is responsible for coordinating and case managing a particular child or young person or their parents. Closer connections and collaboration between these services could lead to significant improvements in quality and effectiveness of the services.

The Joint CSO submission argued that structural barriers prevent greater collaboration between family violence services and statutory child protection services (pp. 46-47).

Professor Humphreys' submission highlighted problems caused by automatic referral to statutory child protection of children living with family violence. When the child or young person's circumstances do not meet the intake threshold no investigation or services are provided (Humphreys submission (a), pp. 4-6, 10). Professor Humphreys argued for alternative pathways for children living with family violence that better recognise the need to strengthen the relationship between a vulnerable child or young person and his or her mother (Humphreys submission (a)).

The Inquiry notes that as part of the progressive development of differentiated pathways within statutory child protection services, the development of appropriate responses to reports of family violence would be a logical extension of the Inquiry's recommendation. For example, police, in partnership with CSOs, play a more active role in responding to family violence.

The Office of the Public Advocate noted a significant increase in the number of families where disability was present (Office of Public Advocate submission, p. 3). The intersection between child protection statutory activities and disability services occurs both when a parent has a disability and/or where a child has a disability.

Submissions to the Inquiry raised concerns about service gaps in assessment and case planning for responses to the needs of children from homes where disability is present. Submissions argued that the protocol in place between statutory child protection and disability services was ineffective at supporting children with a disability (Association for Children with a Disability, p. 3; Disability Services Commissioner Victoria, p. 3). The Public Advocate argued that misunderstandings and, at times, active discrimination occurred against parents with a disability by child protection practitioners (Office of Public Advocate submission, p. 4).

The prevalence of disability is relevant to statutory child protection services in a number of ways. As was discussed in Chapter 2 on vulnerability, where a parent or child has a disability, this can mean that a child is more vulnerable to child abuse or neglect and may be more likely to come into contact with statutory child protection services. A child with a disability may experience greater difficulties with feeding, sleeping and settling and may have more complex needs. These factors impact on the relationship or attachment formed between an infant and their parent and can result in heightened stress, increasing the risk of neglect or abuse.

At the same time, abuse or neglect by a parent may cause a vulnerable child or young person to experience developmental disabilities, ultimately impacting on their transition to independent adulthood. A child with an intellectual disability may also be at a higher risk of child sexual abuse.

The Inquiry considers that the presence of intellectual disability in parents and the presence of disability among children in vulnerable families in Victoria is a significant factor affecting the prevalence of child abuse and neglect. Although the Inquiry heard from some individuals about these issues, it has not been able to fully examine them and make recommendations in the context of the overall effectiveness of Victoria's disability services.

Matter for attention 7

The Inquiry draws attention to the significance of disability as a risk factor among vulnerable families in Victoria affecting the prevalence of child abuse and neglect. This is a matter that should be further considered.

The Inquiry's recommendation for simplification of case planning and for stronger collaboration and diversion pathways dealing with intersecting agencies is set out in Recommendation 21.

Recommendation 21

The Department of Human Services should simplify case planning processes and improve collaboration and pathways between statutory child protection services and other services, particularly family violence and disability services.

The Department of Human Services should increase case conferencing with other disciplines and services related to child protection issues including housing, health, education, drug and alcohol services and particularly for family violence and disability services.

In relation to family violence, consideration should be given to the evidence base for establishing differentiated pathways that lead to improved outcomes along the lines of those pathways discussed in Recommendation 20.

The protocol between statutory child protection and disability services should be strengthened, with more explicit statements around the roles and responsibilities of the different service agencies.

Improving the effectiveness of case management functions

Currently, DHS contracts a range of case management functions to CSOs on a case by-case basis. A number of the major CSOs proposed to the Inquiry that case management responsibility for statutory child protection services should be transferred from DHS to the community sector (submissions from Berry Street, pp. 32, 49-52; Children's Protection Society, pp. 32-33; Anglicare Victoria, p. 19).

The Joint CSO submission proposed that statutory child protection services should be refocused solely on forensic or investigative activities, with case management being transferred to CSOs with appropriate oversight by DHS (p. 50).

Anglicare Victoria argued that the current culture of child protection and related demand issues often meant that cases 'drifted'. Anglicare Victoria argued that refocusing statutory child protection services to cases from receipt of a report up to statutory intervention in court would provide more capacity for DHS practitioners to work intensively and for a longer duration with families at the investigation phase. There would also be more opportunities to co-work complex cases involved with family support and other human services. CSOs would progressively receive statutory case management responsibilities after court orders were obtained (Anglicare Victoria submission, p. 19).

Berry Street argued that DHS should cease directly providing services including case management because it believed this was a role better performed by community sector agencies (Berry Street submission, p. 13).

On the whole, the Inquiry found that these proposals lacked robust evidence to illustrate how a wholesale shift of case management responsibility to the CSO sector would necessarily lead to improved outcomes for vulnerable children and young people.

As was seen with views about the appropriate role of child protection intake, there is not necessarily clear agreement within the community as to what protective intervention work is appropriate for statutory child protection services and what work CSOs might carry out. For example, the CASA Forum submission cautioned against the transfer of statutory functions, arguing that '[n]on statutory agencies should not deal with the legal responsibilities of mandated notifying' because they are not subject to the same scrutiny (p. 9).

A wholesale shift of case management is unlikely to be feasible in the short term due to a range of governance, workforce and funding constraints. The Inquiry's recommendations for differentiated pathways (Recommendation 20), however, will provide greater opportunities for statutory child protection services to, over time, move case management functions to CSOs where this has been shown to improve outcomes. Such case contracting would be carried out on the basis of a greater appreciation of the characteristics of the problems that have led to a child's abuse or neglect, along with clear objectives about the purpose of sharing responsibilities between DHS and the community sector.

A guiding principle for any case contracting changes should be the objective of reducing the number of unnecessary service providers and people in a child's life. Issues arise when multiple agencies and professionals are involved in child and family circumstances including an increased risk of losing focus on the child's needs and diffusion of responsibility. A family experiences disruption and distress to its daily life when it has to manage a host of well-intentioned but uncoordinated service providers.

Managing risk and supporting practitioners

The nature of child protection work involves the application of professional judgment in an environment dominated by risk and risk assessment concerns.

The child protection practitioner's role is to manage this environment and apply professional judgment about the risk that exists to a child's safety and wellbeing. Particularly at intake, when there might be intense time pressures and minimal information that is conflicting or uncertain, this is a difficult balancing act (Mansell et al. 2011, p. 2,078).

The use of standards and procedures to control risk

The working environment for a DHS child protection practitioner involves applying the practice manual - a complex combination of rules, procedures, guidance and advisory notes. DHS advised the Inquiry that the practice manual contains 296 standards within 92 separate pieces of advice. Administrative procedures are required to manage risk but these should enable the exercise of professional judgment, rather than hinder it.

A Humphreys and Campbell submission noted concerns that statutory child protection practice has seen an exponential increase in the number and complexity of practice instructions and standards, without a streamlining of existing expectations or a corresponding rise in the resources to meet the rising standards (Humphreys & Campbell submission (a), p. 2).

In the United Kingdom (UK), the Munro review found that previous well-intentioned practice reforms had skewed work priorities, leading to an over-standardised system that cannot respond adequately to the varied range of a child's needs (Munro 2011b, pp. 9, 14, 51, 61). Similarly, Mansell et al. argues that: '[j]udging the performance of child protection systems by a piecemeal focus on one kind of error and on single cases of errors is a poor source of performance information' (Mansell et al. 2011, p. 2,078).

Munro argued that high-risk sectors such as aviation and health care used alternative people and risk management systems that grappled with high levels of uncertainty and avoiding errors of judgment in practice (Munro 2010, p. 33; 2011b, pp. 86-87).

The Children's Protection Society submission argued that a patient safety systems approach to safety and managing error could move DHS away from a culture of individual blame to an analysis of the human, treatment and systemic factors that provide the multifactorial basis of most errors that occur within complex systems.

The child protection system should aspire to be a high reliability system like medicine and air traffic control ... [where] there is an acceptance that mistakes will be made and so considerable effort is put into training and supporting staff to recognise and recover from such mistakes (Children's Protection Society submission, p. 39).

By reference to bushfire management and aircraft situations, Weick and Sutcliffe argued that organisations operating in high-risk circumstances need systems in place with particular characteristics to support the right people behaviours. These behaviours include continuous monitoring and adaptation to changing circumstances to minimise the likelihood of error and reduce the impact of errors when they do occur (Weick & Sutcliffe 2007, pp. 2, 160).

In these systems, reliability does not depend on strict adherence to processes, rather it relies on the ability to introduce appropriate variation to adapt to changing circumstances (Weick & Sutcliffe 2007, pp. ix-xi).

The Jesuit Social Services' submission argued that frontline practitioners need to be empowered to use their professional judgment to solve the problems they encounter (p. 20). The Joint CSO submission also argued for a fundamental redesign of statutory child protection roles to reduce unnecessary bureaucracy and place accountability and responsibility for decision making closer to the child, young person and their family (p. 50).

Recommendation 22

The Department of Human Services should simplify practice guidance and instructions for child protection practitioners.

The Department of Human Services should reduce practice complexity by consolidating and simplifying the number of standards, guidelines, rules and instructions that child protection practitioners must follow. This process should investigate and apply learnings from comparatively high-risk sectors such as health or aviation in the approach taken to risk management and adverse events.

DHS workforce retention and professional development

Many submissions commented on the workforce issues faced by DHS including staff recruitment, staff retention, professional development and staff morale (St Luke's Anglicare, p. 14; The Salvation Army, p. 22).

Statutory child protection workers must feel as though they are under perpetual review, continually judged to be failing in their protective duties and constantly blamed for adverse child outcomes (Children's Protection Society submission, p. 38).

The Joint CSO submission argued that demand pressures, high rates of turnover, poor job design and unwieldy and cumbersome administrative layers hampered DHS' capacity to deliver an effective statutory response (p. 49).

Similarly, the Parenting Research Centre argued that 'simplistic and sensationalistic media reporting have helped create an undeserved sense of chaos and crisis in child welfare, obscuring the good work as well as the real challenges faced by the dedicated professionals who work in the sector in Victoria' (Parenting Research Centre submission, p. 4).

The Take Two Partnership submission argued that there is insufficient understanding in child protection and foster care services about how trauma and disrupted attachment affects young children and infants and brain development. The Take Two Partnership argued for greater workforce training and specific development initiatives about developmental and therapeutic needs for young children and infants (Take Two Partnership submission, p. 7).

The people management and workforce reforms proposed by DHS to provide more support for child protection practitioners in their risk assessment and decision making are discussed in more detail in Chapter 16.

Information and communication technology systems to support practice

In all consultations held with frontline child protection practitioners the Inquiry heard major concerns about the efficacy and the operation of the CRIS/CRISP information technology systems. Submissions argued that current systems are time consuming and require simplification (Humphreys & Campbell (a), p. 2). Berry Street argued that the CRIS/CRISP systems lack basic reporting functions and there is no return on effort to input data to support monitoring, evaluation and quality improvement (Berry Street submission, p. 33). In a report prepared in collaboration with the Victorian Auditor-General, the Victorian Ombudsman commented on a number of issues arising from CRIS including inadequate training, poor help-desk support and slow responses to functionality change requests.

The Ombudsman observed:

CRIS has been in place for three years, and yet it remains plagued by the concerns of Child Protection workers interviewed who state the system has caused stress, frustration and an increased desk-based workload (Victorian Ombudsman 2011d, pp. 89-90).

DHS advised the Inquiry that a range of issues had been identified in 2010 with the efficiency, effectiveness and safety of its client information system, CRIS/CRISP. In particular, the areas identified for improvement were the need for greater training, system support teams and establishing business processes that staff at all levels could understand and follow. A range of CRIS business improvement projects are currently underway to address these findings. In response to the Ombudsman's report, DHS noted that additional funding had been requested in August 2011 to address issues arising from CRIS.

The Inquiry supports continued implementation of the Victorian Ombudsman's recommendations regarding the CRIS and CRISP ICT systems including continuing:

- To strengthen supporting systems and efforts to improve the CRIS/CRISP systems;
- To increase and improve training and support available to staff so that the CRIS system is easier to use and more widely understood; and
- Projects to enhance the capability, efficiency and effectiveness of the CRIS/CRISP systems.

Trust and public confidence

Many submissions commented on the negative impact of what they describe as sensationalist media reporting and the unhelpful nature of current public debate surrounding statutory child protection services.

The Australian Childhood Foundation submission argued that there is insufficient publicly available data about decision-making patterns and benchmarks against which Victoria's system for protecting children could be evaluated. This lack of transparency was argued to impede continuous, transparent review and improvement (Australian Childhood Foundation submission, pp. 2, 6-7).

Greater clarity and publicly available information about the role and expectations for the performance of statutory child protection services is fundamental to the maintenance of public trust.

Informed commentary relies on the availability of clear indicators and standards against which the performance of statutory services can be evaluated or assessed. The major performance standards tool used by child protection practitioners is the practice manual. This document, while it contains supporting advice and guidance for practitioners, contains far too many detailed instructions and advice notes to be suitable for use as a public indicator framework. In addition, performance information against the standards set out in the practice manual is not publicly released.

As proposed in Chapter 6, publicly available and easier to understand performance reporting will support more informed public debate about the efficacy of statutory child protection services. The Inquiry's recommendation about public reporting contained in Chapter 6 and also referred to as part of the governance and accountability recommendations in Chapter 21 will support greater transparency and accountability about the performance of statutory child protection services.

9.5.3 *A child's need for stability and permanency planning*

It is well established that good outcomes for children and young people in the statutory system depend on safe reunification with their family or stable, long-term placements. Improved outcomes for children and young people in long-term placements are also linked to a child's age at his or her entry point into long-term care and the extent of any emotional or behavioural disturbance. The timeliness of decisions made in respect of children requiring long-term placements are therefore an important factor influencing a child's outcomes.

Adoption and permanent care

Whether adoption or permanent care best meets the needs of a child who cannot return to their biological parents' care or to a member of the extended family, will depend on their individual circumstances. It is a matter that requires very careful and timely consideration.

Adoption is one way of securing a permanent substitute family for a child in care for whom there is little prospect of being reunited with their biological parents and where there is no member of the extended family who is able to provide a suitable stable placement. There are two types of adoption orders; an open adoption where the biological parents give their consent to the child's adoption and where continuing contact may occur with the child; or an adoption order where dispensation of parental consent to adoption is granted by a court.

There are very few adoptions of children in State care in Victoria, and adoptions that are based on the dispensation of parental consent are extremely rare. Only two adoption orders dispensing with parental consent were made across Australia in 2009-10 (AIHW 2010, p. 26). It is unknown to what extent, if at all, DHS seeks the consent of biological parents to adoptions of children for whom there is little prospect of returning to their care. The Inquiry examined the current provisions relating to the requirements for a dispensation of parental consent to adoption under section 43 of the *Adoption Act 1984* and concluded that these are comprehensive and sound. It was not possible to determine why there are so few adoptions of children whose circumstances would make them eligible under these provisions.

The Inquiry considers that children should be afforded the full protection of the law in order to secure their best interests. Consequently, DHS should, as a matter of priority, pursue timely action to secure the release of children for adoption if parental consent is unavailable and if the child's circumstances would make them eligible for parental dispensation of consent to adoption. This should be done in circumstances where suitable adoptive parents are available and where there is no suitable member of the extended family who can provide an alternative permanent placement for the child.

While additional resources may be required to pursue this course of action, and in some instances, to provide post-adoption support that a child with special needs may require, the savings are likely to be very considerable compared with the cost of the child remaining in care until the age of 18. The reason for the Inquiry advocating this course of action, however, is not financial but is advocated because the right to adoption should be available to eligible children for whom this is appropriate and who have no other prospect of a secure and stable family to whom they can belong.

There may also be wider benefits to the out-of-home care system by giving greater emphasis to adoption. Suitable individuals and families who would be willing to consider adoption but who are not willing to consider foster care or permanent care, could expand the pool of carers, thus reducing the pressure on foster and permanent care.

Another way in which placement stability may be secured for a child in care who is unable to return to their biological family is through a permanent care order under sections 319-327 of the CYF Act. Parents may consent to a permanent care order, but such consent is not essential. The order ceases when the child turns 18 and the Children's Court sets the frequency of contact a child will have with their biological family. A permanent care order may be revoked and, while this is unusual, the Inquiry has heard examples of the insecurity that the prospect of this revocation may engender in the child and the carers. Unlike adoption, the government continues to provide some financial support for children placed under a permanent care order.

When a child enters care at a later age and their identity is based on their biological family with whom continuing contact is important to the child, then a permanent care order is likely to be more appropriate. Where a child has spent little time in their biological family, enters care at a young age, does not have a significant attachment to their biological parents and there is no member of the extended family to provide suitable stable placement for the child, then adoption may be more appropriate.

A recent UK study suggests that the main factors influencing outcomes in care are age, pre-placement adversity and delay in placement (that is, exposure to adversity). Where adversity levels are similar, children in stable foster care and adopted children had similar needs and outcomes when they arrived at their placements at similar ages. Overall there were no significant differences in outcomes between children in stable foster care and children who were adopted (Beek et al. 2011, pp. 2-4). Local evidence on comparative outcomes between adoption and permanent care is scant, however, and it must be noted that children in the two groups tend to differ in age as well as background and abuse histories (Rushton 2003, p. 19).

A number of legislative changes were made alongside the Child FIRST reforms to promote the objective of greater placement stability and for permanent care decisions to be made earlier for children in out-of-home care. The provisions (s. 170, CYF Act) sought to align the developmental needs of a child in out-of-home care and the time available for a parent(s) to demonstrate sufficient change for their child to be returned to their care.

In Victoria there were 203 permanent care orders issued in 2009-10. The average age of children when they commence permanent care orders is around 6.5 years, and the average age of children on permanent care orders is 10.5 years. Nearly 90 per cent of these orders were made more than two years after the initial substantiation of harm. The average time taken between a child's first report and their ultimate permanent care order, at just over five years (Inquiry analysis of information provided by DHS), is too long. For children who have been abused and known to statutory child protection services at a young age, it takes too many years for a permanent care order to be granted when this is necessary to ensure their safety and wellbeing. During this time, many children are subjected to multiple placements, compounding psychological harm.

Finding 4

The Inquiry finds that the current average time taken for permanent care orders to be granted, when this is necessary to ensure a child's safety and wellbeing, is too long. On average, it is five years between a child's first report and a permanent care order.

The Inquiry has heard evidence that the process for securing a permanent care order is complicated and ineffective. It was argued that a failed reunification plan was required before a permanent care order would be granted. Failed reunification plans are traumatic, can delay the formation of healthy attachment with carers, and may lead to prolonged exposure to harm (submissions from Jordan, pp. 1-2; Take Two Partnership, p. 5; The Salvation Army pp. 12-13).

Berry Street's submission argued that Victoria today is doing worse than it was a decade ago in providing placement stability for children and young people (p. 30). The CatholicCare submission argued that permanent alternative care decisions were not made in a timely enough manner, causing significant detriment to the needs of the children involved (p. 14).

The Inquiry considers there are too many barriers to timely, stable, long-term permanent care for vulnerable children. The Inquiry heard barriers included the lack of support for permanent carers, a perception that DHS or court processes are reluctant to fully implement permanent placement planning and the practical consequences of practitioners needing to plan for both reunification and permanency simultaneously.

Put simply, the legislative reforms to the CYF Act have not achieved their desired objective of improving the likelihood that permanent care orders are made in a timely manner to improve outcomes for vulnerable children and young people. It should be noted that Chapter 10 makes recommendations addressing the lack of support measures that mean some carers are reluctant to apply for permanent care orders.

Recommendation 23

The Department of Human Services should identify and remove barriers to achieving the most appropriate and timely form of permanent placements for children unable to be reunited with their biological family or to be permanently placed with suitable members of the extended family by:

- Seeking parental consent to adoption, and where given, placing the child in a suitable adoptive family;
- Pursuing legal action to seek the dispensation of parental consent to adoption for children whose circumstances make them eligible under section 43 of the *Adoption Act 1984*;
- Resolving the inconsistency between practical requirements for child protection practitioners to simultaneously plan for reunification while contemplating permanent care arrangements; and
- Reviewing the situation of every child in care who is approaching the stability timeframes as outlined in the *Children, Youth and Families Act 2005*, to determine whether an application for a permanent care order should be made. Where it is deemed not appropriate to do so (for example, where a child's stable foster placement would be disrupted), the decision not to make application for a permanent care order should be endorsed at a senior level.

9.6 Conclusion

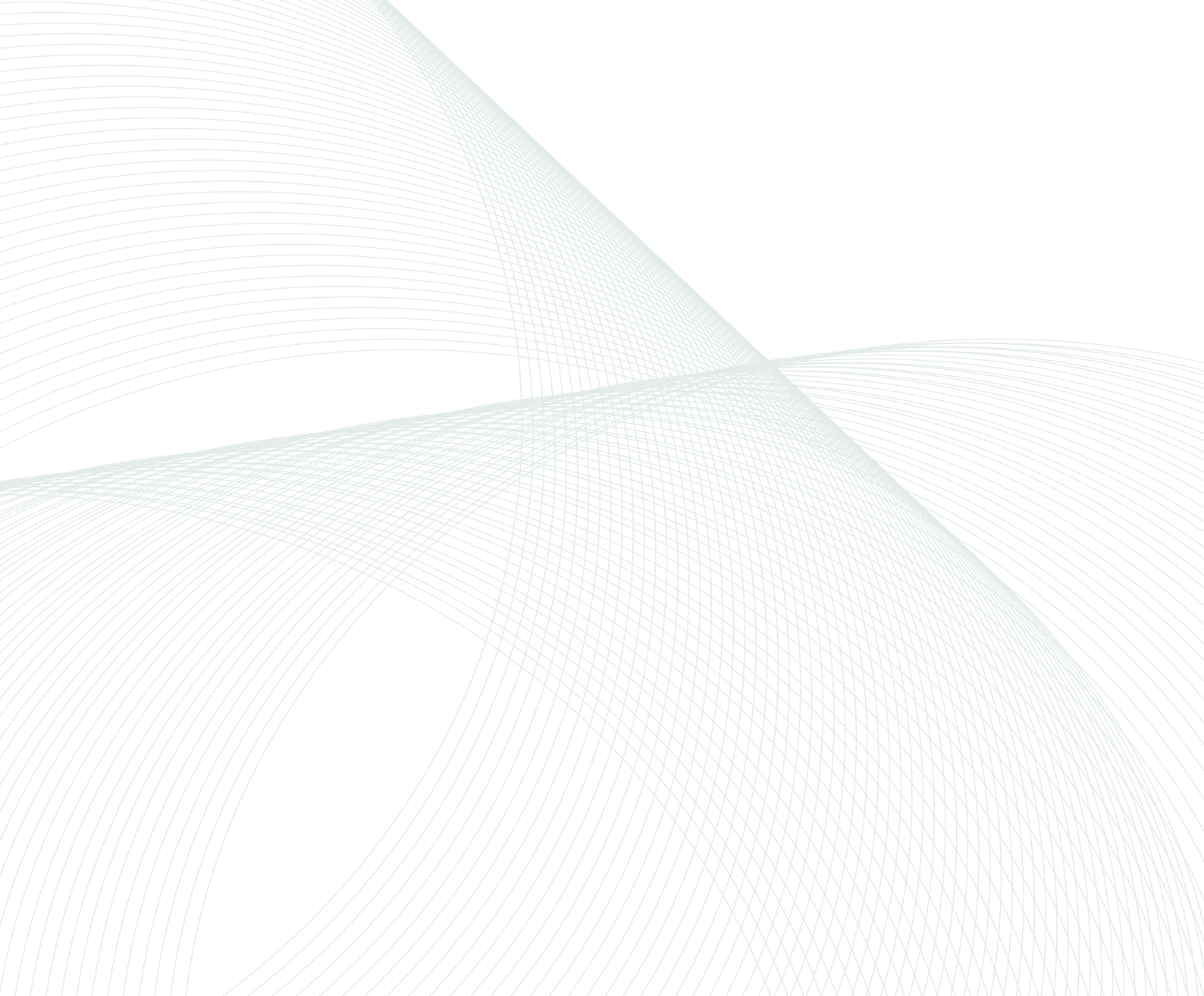
Among the broad range of service responses available to Victoria's vulnerable children and young people, statutory child protection services play an important role. By their very nature, these services are an interconnected chain of activity ranging from intake to investigation, protective intervention and assessment, through to protective orders and placement of children in out-of-home care.

Informed by concerns raised in submissions and available performance data, the Inquiry has examined a number of issues relating to the Victoria's statutory child protection services. These issues have included:

- The question of whether statutory child protection services are sufficiently resourced to intervene when required to protect vulnerable children and young people, given:
 - The changing nature of child protection reports and increasing knowledge about the risk factors likely to give rise to child abuse and neglect;
 - The continuing rise in reports to statutory child protection services and expectations that these reports will be managed appropriately;
- The efficiency and effectiveness of child protection practice, encompassing a range of issues arising from re-reporting and resubstantiation trends but also recognising some children and families are clients of both statutory child protection services and family support services; and
- Once a child has been brought into the statutory child protection system, the need to improve stability in placements for vulnerable children and young people, to avoid causing further harm and trauma.

Statutory child protection services have not been established to address the fundamental underlying causes of child abuse and neglect.

The Inquiry's recommendations in previous chapters are part of a package of reforms that seek to balance the role of statutory child protection services with universal, secondary and specialist adult services as part of a system that meets the needs of vulnerable children. The incidence and impact of child abuse and neglect in Victoria can only be reduced if all of the relevant areas across government accept responsibility for services delivered to vulnerable children and families. The introduction of a whole-of-government strategy and accompanying performance indicator framework in Chapter 6, better use of preventative and early intervention services from Chapters 7 and 8, and, critically, the governance and regulatory changes recommended in Chapters 20 and 21 will establish a framework for government agencies to work together better to address the needs of vulnerable children.



Part 4: Major protective system elements

Chapter 10:

Meeting the needs of children and young people
in out-of-home care

Chapter 10: Meeting the needs of children and young people in out-of-home care

Key points

- Currently around 5,600 Victorian children and young people are placed in various forms of home-based and residential care.
- The major trends and structure of Victoria's out-of-home care include:
 - an annual growth over the past decade of 4 per cent in the number of children and young people in care driven by the increase in the time children and young people are spending in care;
 - Aboriginal children and young people now represent one in six Victorian child and young people being placed into care;
 - one in eight Victorian children and young people entering out-of-home care are infants;
 - a significant expansion in the proportion of kinship care placements offsetting a decline in foster care placements;
 - marked regional variations in the proportion of children and young people being placed in care; and
 - 30 per cent of children and young people placed in care in 2009-10 had been placed in care previously.
- There are major and unacceptable shortcomings in Victoria's out-of-home care system including placement instability and poor educational outcomes for children and young people in out-of-home care.
- The Government should, as a matter of priority, establish a comprehensive five year plan for Victoria's out-of-home care system. The core objectives of this plan should be to:
 - reduce over time the growth in the number of Victorian children and young people in out-of-home care to the overall growth in Victorian children and young people;
 - improve the quality and stability of out-of-home care placements; and
 - improve the education, health and wellbeing outcomes for children and young people placed in care, including by ensuring their therapeutic needs are met.
- Implementation of this plan will require a comprehensive and sustained long-term strategy and significant investment.

10.1 Introduction

Statutory child protection services in Victoria are provided to protect children and young people who are at risk of harm within their families, or whose families do not have the capacity to protect them. This chapter focuses on those children and young people for whom the risk of harm is assessed as too great to live at home with their parents and for whom the Department of Human Services (DHS) arranges a placement away from their families. These placements are commonly referred to as out-of-home care placements. Out-of-home care broadly consists of two types:

- Home-based care where placement is in the home of a carer who is reimbursed for expenses for the care of the child – foster care, relative/kinship care and permanent care are all forms of home-based care; and
- Residential care where the placement is in a residential building whose purpose is to provide placements for children and young people and where there are paid staff.

This chapter: outlines the current legislative framework relating to out-of-home care placements; identifies the broad objectives and key elements of the current out-of-home care system; provides an overview of the out-of-home care placements and recent trends; presents an assessment of overall performance and the key issues facing the out-of-home care system identified during the Inquiry process; and sets out a number of key conclusions and recommendations.

The chapter also draws on the report prepared by the CREATE Foundation on the views and opinions of children and young people about the out-of-home care system in Victoria. CREATE Foundation, which is generally recognised as the peak body for children and young people in out-of-home care in Victoria was contracted by the Inquiry to undertake an online and focus group consultation process with children and young people aged between eight and 25 years with a care experience. A summary of the CREATE Foundation report is at Appendix 3 and the full report is available from the Inquiry website.

On any single day in Victoria, approximately 5,600 children are living in out-of-home care placements, including children in permanent care. Around 90 per cent are generally in home-based care placements and the remainder generally in residential care. Over the 10 years to end June 2011, the number of children and young people living in out-of-home care placements increased from 3,882 to 5,678 – a growth of 46 per cent. At the end of June 2011, 4.6 Victorian children and young people per 1,000 aged 0–17 years were living in out-of-home care placements compared with 3.4 Victorian children and young people per 1,000 aged 0 to 17 years at the end of June 2001 (provided by DHS).

The background factors associated with out-of-home placements and other periods children and young people spend in out-of-home care vary considerably. Many children in out-of-home care are reunited with their families within a short period after the families receive support or address the issues impacting on the child's safety and wellbeing. Others may experience longer periods in care reflecting family circumstances, the issue of safety and the effects of trauma, abuse and neglect.

The majority of out-of-home care placements in Victoria are provided and managed by not-for-profit community service organisations (CSOs), many of which have long histories of providing care to vulnerable children across Victoria. DHS funds these placements and related services through funding and service agreements with the individual CSOs. As part of the overall policy responsibility, DHS has established a quality and regulatory framework for the care provided to children in the system and monitors CSO performance.

In summary, the Inquiry found there are major and unacceptable shortcomings in the quality of care and outcomes for children and young people placed, as a result of statutory intervention, in Victoria's out-of-home care system. Further, the Inquiry considers there a number of long-term factors impacting on the outcomes and sustainability of the current approach to providing accommodation and support services to children in out-of-home care. Major reform of the policy framework, service provision and funding arrangements for Victoria's out-of-home care system are therefore urgently required.

10.2 Out-of-home care policy and service framework

The overall purpose of out-of-home care is to provide children and young people, who are unable to live at home due to significant risk of harm or parental incapacity, with a stable and suitable place to live and other supports that ensures their safety and healthy development. The majority of children and young people placed in out-of-home care are subject to a legal order from the Children's Court.

10.2.1 Legislative framework

The *Children, Youth and Families Act 2005* (CYF Act) sets out the requirements under which the Secretary of DHS or delegate may place a child or young person in out-of-home care. Section 173 *Placement of children* applies to a child:

- (a) Who is in the custody or guardianship of the Secretary under the Act; or
- (b) For whom the Secretary is the guardian under the *Adoption Act 1984*; or
- (c) In respect for whom the Secretary has authority under the *Adoption Act 1984* to exercise any rights of custody.

The length of out-of-home care placements varies according to the individual circumstances and the court order that is in place for that particular child. The specific orders covered by section 173 include: interim accommodation orders; custody to Secretary orders; guardianship to Secretary orders; long-term guardianship to Secretary orders; interim protection orders; permanent care orders; and therapeutic placement orders.

The Secretary of DHS has administrative responsibility for the nature of the out-of-home arrangements guided by section 174 *Secretary's duties in placing child*, which requires that the Secretary or delegate when placing a child referred to in section 173:

- (a) Must have regard to the best interests of the child as the first and paramount consideration; and
- (b) Must make provision for the physical, intellectual, emotional and spiritual development of the child in the same way as a good parent would; and
- (c) Must have regard to the fact that the child's lack of adequate accommodation is not by itself a sufficient reason for placing the child in a secure welfare services; and
- (d) Must have regard to the treatment needs of the child.

In relation to Aboriginal children, sections 13 and 14 of the Act set out the matters the Secretary of DHS, in line with the Aboriginal Child Placement Principle, must have regard to, where it is in an Aboriginal child's best interest to be placed in out-of-home care. In particular, the Secretary of DHS:

- Is required to consult with the relevant Aboriginal agency when consideration is being given to placing an Aboriginal child in out-of-home care;
- Must ensure the involvement of relevant Aboriginal community members and Aboriginal family decision making processes when planning for an Aboriginal child to be placed in out-of-home care;
- Is to give priority, wherever possible, to placement with the Aboriginal extended family or relatives and, where this is not possible, other extended family and relatives; and
- If these placement options are not feasible or possible, have regard to further criteria including the child's Aboriginal community, Aboriginal family-based care and close proximity to the natural family, and maintenance of the child's cultural identity in making a placement in out-of-home-care.

In addition to out-of-home-care placements linked to statutory orders, parents of children who are the subject of a child protection report may place their child voluntarily in out-of-home care on a child care agreement. Part 3.5 of the CYF Act regulates these arrangements that are designed to alleviate immediate risks, where the parent acknowledges the risks and is willing to engage in a realistic and safe plan to address them.

Further to these out-of-home care placements that are covered by the Act, a small number of children are voluntarily placed in care due to parental illness or a family crisis, and where no other placement option is available. In these situations, a voluntary child care agreement is made between the parents or guardian and the CSO.

10.2.2 Objectives and key elements

DHS' *Child Protection Practice Manual* sets out a range of core goals, principles and processes for the placement of children and young people in out-of-home care.

The core goals for placement listed include:

- The care provided by out-of-home carers should be consistent with that provided by any caring parent in the community;
- Child-centred family-focused care – namely the primary focus is on the safety and development of the child, but in the context of the importance of their ongoing relationships with parents, family and their social relationships; and

- Placement stability – child protection services and out-of-home care services need to work hard to minimise the number of placement changes for children and to make placements as stable as possible.

A list of core principles is also identified to guide out-of-home care placements including in addition to the stability and family focus goals:

- Safety – children will reside in a safe environment, free from abuse or neglect;
- Potential – children will receive good quality care, that aims to meet their emotional, social, educational, physical, developmental, cognitive, cultural and spiritual needs and provides them with an opportunity to reach their full potential;
- Participation – children and their families will be provided with opportunities and assistance to participate in all decisions that affect them;
- Respect – children and their families will be treated respectfully and with dignity at all times and will not be spoken to or about in derogatory ways;
- Individuality – the individuality of each child will always be acknowledged. That is, the ethnic origin, cultural identity, religion and language of each child and family will be recognised and respected in the planning and provision of each placement;
- Cultural relevance – children in out-of-home care come from a range of cultures. Each child will reside in environments that are culturally relevant and that highlight the importance of their cultural heritage;
- Gender and sexuality – consideration will be given to the gender and sexuality of each child in planning and delivery of services;
- Disability – consideration will be given to any disability a child may have in the planning and delivery of services;
- Primary attachment – each child will be given the opportunity to maintain and form significant, consistent and enduring emotional connections with one or more primary individuals in their lives, and promote positive, caring and consistent relationships for a child with their family, peers, significant others, caregivers and schools; and
- Leaving care – equipping a young person for life after care is vital, so staff and carers will work with a young person to develop skills that are essential for transition to a new placement, independent living or successful return home (DHS 2011k, advice no. 1407).

Home-based care

Home-based care involves a child living with a full-time carer in the carer's home. DHS provides reimbursement for everyday living expenses of the child with direct fortnightly payments supplemented by discretionary payments for abnormal client expenses or special needs of the child. There are three main types of home-based care:

- Kinship care, where the caregiver is a family member or a person from the child's social network. DHS has historically directly managed kinship care placements but has recently transferred responsibility for a proportion of kinship care placements to selected CSOs;
- Foster care involving placements in a volunteer caregiver's home. CSOs are responsible for recruiting, training and supporting foster carers; and
- Permanent care arising from permanent care orders under the CYF Act whereby the Children's Court may grant permanent custody and guardianship of a child to a suitable person.

Residential care

Residential care involves the child residing in a facility where care is provided by paid staff working in shifts. A number of children usually reside in the facility and residential facilities may be classified according to the level of case complexity and the level of challenging behaviour the unit is equipped to accommodate. In addition to the general residential care models, DHS also funds:

- The Lead Tenant Program designed to provide semi-independent accommodation options for young people aged 13 to 17 years to assist with preparing them for transition to independent living; and
- A number of therapeutic residential care pilots designed to trial more intensive therapeutic responses to children's trauma and attachment disruption arising from prior abuse and neglect.

Brief history of out-of-home care

The pattern and service responsibility for out-of-home care placements has undergone significant changes since the 1970s as part of the broader reforms to the statutory child protection system outlined in Chapter 3. In the 1960s and prior, the out-of-home care system in Victoria was dominated by large institutions housing most children whose parents were unable to care for them. Only one-third were in foster care. A move towards community-based residential care, as part of the broader 'de-institutionalisation' philosophy, saw these larger institutions progressively closed throughout the 1970s and 1980s.

The *Children and Young Persons Act 1989* also provided for the separation of services for children who were detained for committing criminal offences from those children placed in out-of-home care because their families could not care for them.

Throughout the 1980s and 1990s, the overwhelmingly preferred models of care became home-based arrangements such as foster care or kinship care placements, with kinship care now the preferred placement model. Also in the 1990s, service responsibility for community-based residential units operated by the government was transferred to CSOs.

Out-of-home care today

More recently, the overwhelming evidence in Australia and elsewhere that simply removing children and young people from at-risk or untenable family circumstances and placing them in care does not of itself lead to an improvement in their wellbeing, has led to a broader focus on outcomes and the quality and nature of care provided.

In line with this evidence, DHS' objectives for the out-of-home care system, as outlined above, have broadened beyond meeting a child's basic accommodation, food, health care and schooling needs, to including the full range of a child's needs and outcomes in critical life areas such as emotional and behavioural development, family and social relationships, identity, social presentation and self-care skills.

As part of this broader focus, there has also been an important and growing emphasis on developing therapeutic approaches to out-of-home care placements that explicitly recognise that healing the traumatic impact of abuse and neglect and the disrupted attachment that ensues requires creating and sustaining sophisticated care environments. Basic tenets of the approach include 'the skilled therapeutically intentional use of daily interactions as a vehicle for delivering healing interventions' (Downey & Holmes 2010, p. 1).

The extent to which these objectives and key elements are meeting the desired goals is addressed later in Section 10.4.

10.2.3 Out-of-home care processes, funding arrangements and standards

Processes

As outlined in Chapter 9 there are two key statutory child protection processes involved in a decision by DHS to remove or seek the removal of a child from their parent's or family's care: risk assessment and case planning.

The risk assessment provides the basis for informed decisions about a child's needs, the family's ability to provide a safe and supportive environment and the decision to remove a child from the family home. The case plan, as outlined in Part 4.3 of the CYF Act, sets out the decisions, goals and strategies relating to the present and future care and wellbeing of the child, including the placement of and parental access to the child. The case plan includes any stability plan prepared for that child for long-term out-of-home care.

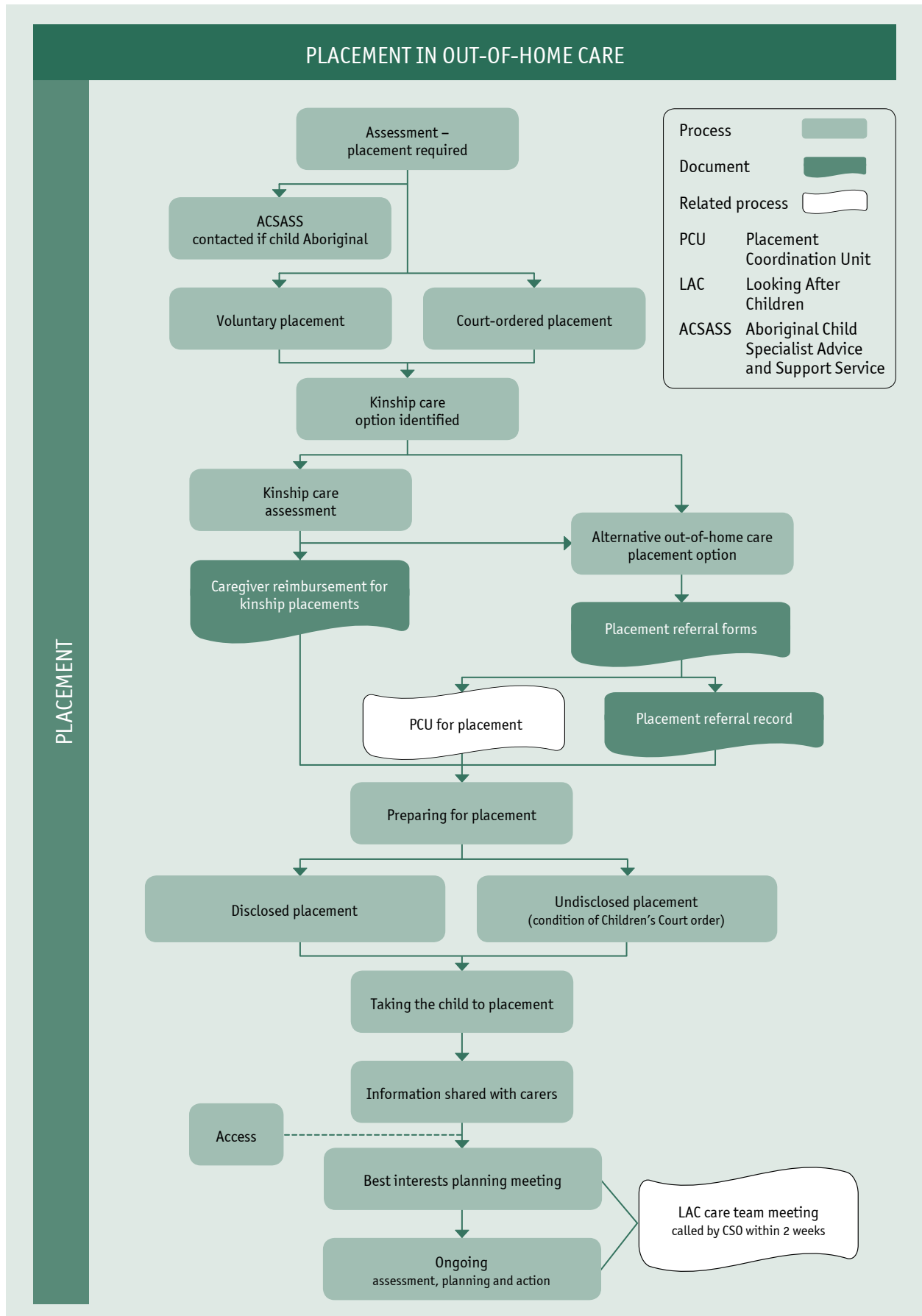
Figure 10.1 sets out the flowchart DHS has developed of the process for placements in out-of-home care including the key phases. The planning and coordination of placements is undertaken as part of the activities of the regional offices of DHS.

As outlined in the flowchart, the placement planning process emphasises the priority to be given to kinship care in the first instance and, in relation to Aboriginal children, the requirement for consultation with the Aboriginal Child Specialist Advice and Support Service.

The placement planning process and the initial placement decisions are the critical steps in achieving appropriate and stable out-of-home placements that support 'the physical, intellectual, emotional and spiritual development of the child in the same way as a good parent' (s.174 (1) (3), CYF Act). To underpin these decisions and the ensuing out-of-home care placements, DHS has developed a range of practices, funding arrangements and standards.

Paramount are the assessment and planning of the child's best interests and promoting and monitoring the child and young person's development. In addition to the child's case plans, including stability plans required as part of the statutory child protection phase, DHS policies and practices include the following:

Figure 10.1 Victoria's out-of-home care placement processes



Source: DHS 2011k, advice no. 1397

- At the point of a child's placement, the establishment of a *care team* to facilitate collaboration and prompt 'all parties involved to consider things any good parent would naturally consider when caring for their own Child' (DHS 2011k, advice no. 1397). The composition varies depending on the specific issues and needs of the child and family but generally includes the child protection practitioner, the community service agency case worker, the carers (including the residential worker) and, as appropriate, the child's parents and other adult family members.
- Using the *Looking After Children framework* for supporting outcomes-focused collaborative care for children and young people placed in out-of-home care as result of child protection intervention. The *Looking After Children framework*, which was originally developed in the United Kingdom (UK) and adopted by DHS in 2002, sets the framework and practice tools for considering how each child's needs will be met while the child is in out-of-home care. The framework identifies seven life areas in considering the child's needs and outcomes – health; emotional and behavioural development; education; family and social relationships; identity; social presentation; and self-care skills – and includes a set of supporting practice tools: essential information record; care and placement plan; assessment and progress record; and review of the care and placement plan.
- For each Aboriginal child placed in out-of-home care, a cultural plan setting out how the Aboriginal child is to remain connected to his or her Aboriginal community and to his or her Aboriginal culture must be prepared.
- As part of the Partnering Agreement between DHS, the Department of Education and Early Childhood Development (DEECD), Catholic Education Commission of Victoria and Independent Schools Victoria on *The Out-of-Home Care Education Commitment*, the establishment of a school support group - including parent, guardian or caregiver, child (where appropriate) and relevant school, DHS and CSO representatives – and preparation of an individual education plan to address the particular education needs of the child or young person in care.
- Advice to care teams on the preparation and planning required for young people aged 16 to 18 years in out-of-home care to transition to independence and adulthood including the preparation of a transition plan. Chapter 11 considers in more detail the legislative framework and statutory child protection process related to young people leaving care.

Structure of out-of-home care and funding

Critical to the achievement of the goals and aspirations for children and young people placed in out-of-home care are the quality of the out-of-home placements and the provision of appropriate interventions and supports to not only the child or young person but the caregivers as well.

DHS has the lead responsibility for the policy and funding arrangements of out-of-home care placements. CSOs are funded and have the service provision responsibility for foster and residential care placements and, more recently, case management responsibility for a number of kinship care placements arranged by child protection workers following the establishment of the kinship care arrangements between the statutory child protection system and the family.

In response to the increase in the demand for out-of-home placements, the long-term decline in the availability of foster carers and the changing and challenging needs of many children and young people placed in out-of-home care, DHS has introduced a range of additional options and supports to the home-based and residential care framework. Figure 10.2, which depicts the current out-of-home care system, indicates the trend towards increasing specialisations and supports within the out-of-home care system.

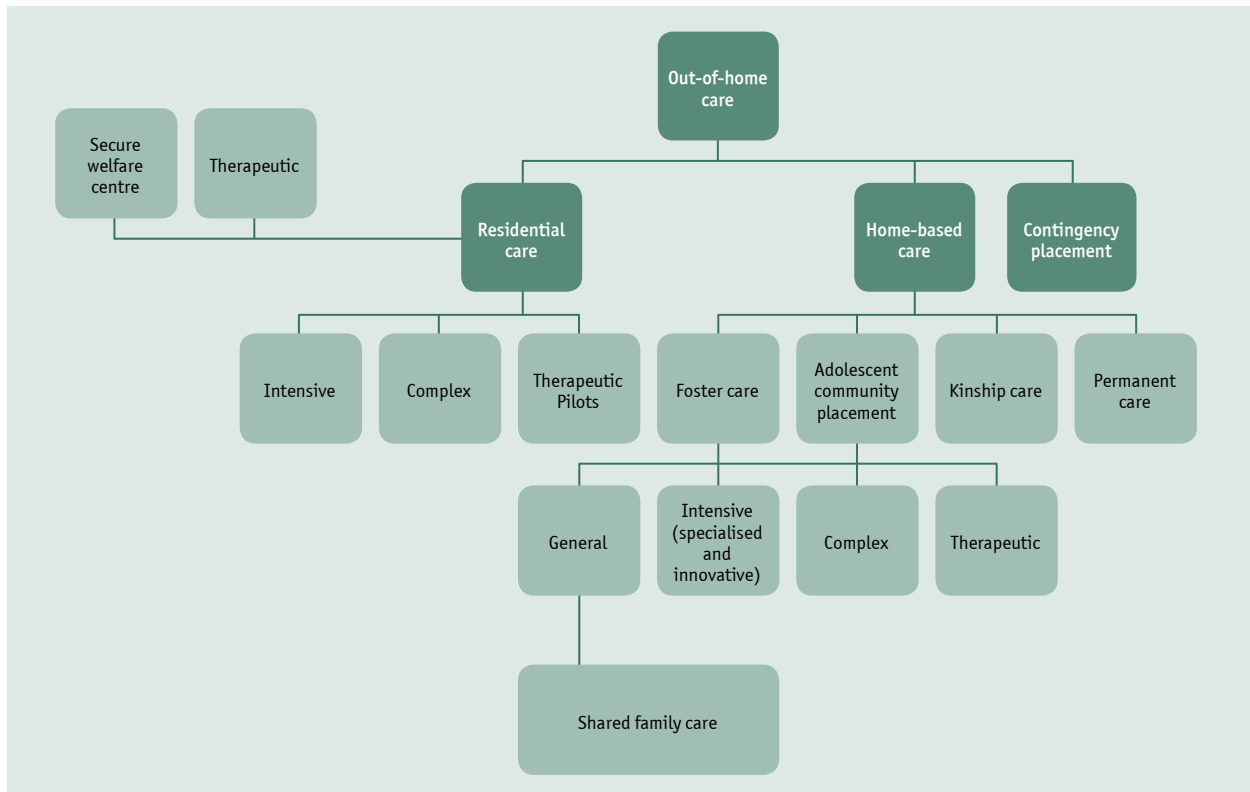
Within the home-based foster care component, the graduations span general, complex, intensive and therapeutic foster care depending on the assessed needs and specialised supports. For example, home-based complex care generally covers one-to-one care for children and young people with very high, complex needs where intensive placements have been inappropriate or unsuccessful because of the child's challenging behaviour or additional needs. Home-based intensive and complex carers are given additional training, reimbursement and support.

The therapeutic approaches in home-based care include therapeutic foster care, which provides additional supports to the child and carers and the dedicated involvement of both placement and therapeutic specialist providers, and access to the statewide developmental therapeutic program, known as Take Two. Take Two supports children and young people in the statutory child protection system.

The residential therapeutic approach involves models being trialled under the Therapeutic Residential Care Pilot Projects initiative commenced in 2007-08. Elements of the pilots include:

- Additional support for residential workers to provide informed care and guidance to assist in addressing the child and young person's everyday and exceptional needs and development delays that impede healthy functioning;

Figure 10.2 Victoria's out-of-home care system



Source: Adapted from information provided by DHS

- Focuses on hearing the child and young person's voice; and
- A strengthening of the child or young person's connections with their family, community and culture.

Reflecting demand pressures and specific placement requirements for children or young people with very complex needs, DHS in recent years has funded a range of one-off or contingency placements in various accommodation arrangements to meet short-term emergencies. These arrangements have included motels, serviced apartments, caravans/cabins and youth hostels. In the year to March 2011, DHS services advised that 124 contingency placements had been made compared with 153 placements in 2009-10. Sixty-eight of the placements had been in youth hostels and 34 in caravans/cabins.

An important element influencing the extent of entry into out-of-home care and the duration of care is the emphasis given to placement diversion and family reunification activities. DHS provided the Inquiry with data on the total number of reunifications with parents for children and young people in 2009-10 and 2010-11. In 2009-10 there were 1,179 reunifications relating to 1,087 individual children and, in 2010-11, 1,130 reunifications relating to 1,046 individual children.

DHS does not collect information on unsuccessful reunification attempts but advised that snapshot reviews indicated:

- Of the 1,087 children reunited with parents during 2009-10, 173 or nearly 16 per cent were recorded as having returned to out-of-home care on 30 June 2010; and
- Of the 1,046 children reunited with parents in 2010-11, 141 or 13.5 per cent were recorded as having returned to out-of-home care on 30 June 2011.

On placement diversion, as part of a range of out-of-home care initiatives announced in the 2009-10 State Budget, DHS has implemented four intensive in-home assistance pilots, known as Family Coaching pilots, aimed at children and young people and their families who are at risk of coming into care or have come into care for the first time. These pilots focus on infants aged under two years, older children aged 10-15 years and Aboriginal children. DHS has advised the preliminary data indicates these pilots are having a significant impact on assisting families provide a safe and supportive home for their children and thereby pre-empting placement in out-of-home care and achieving successful family reunifications.

In the 2011-12 State Budget, the government announced that \$12.8 million over four years had been allocated to establish an effective model of health and educational assessment, and treatment and support for children entering residential care. The aims of the funding are to enable early identification of children's physical health and development and mental health needs, and provide support to enable sustainable school engagement and educational achievement.

An important but less well documented and understood component of the out-of-home care system in Victoria is the availability and usage of respite care. Respite care usually takes the form of foster care provided for a short period when the regular carer is unable to care for the child for a range of reasons. The respite care can be regular or on an emergency basis, and is designed to support parents as well as foster carers, kinship carers and permanent carers. In Victoria, respite care for foster carers forms part of the overall arrangements for foster carers involving CSOs. Anecdotal evidence suggests these respite arrangements form an important part of the foster care system.

However, as outlined in Section 10.2.1, placements of children in out-of-home care can also be made outside of a statutory order. In specific instances, the placement in out-of-home care can form an important part of the support to a family that is the subject of a statutory child protection intervention. DHS reported that 893 child care agreements were entered into 2010 of which 57 per cent were linked to statutory child protection intervention and the remaining 43 per cent direct arrangements between CSOs and families to accommodate emergency and other circumstances.

Funding

The overall funding for the out-of-home care system forms part of the annual budget allocations to DHS. In 2009-10, direct expenditure on residential care totalled around \$90 million, with some \$100 million spent on home-based care including caregiver reimbursements.

There are three principal elements to the current funding of out-of-home care arrangements:

- Funding to CSOs for the provision of home-based foster care and residential places. CSOs are funded for recruiting, assessing, training and supporting foster carers. They are also funded to provide case management and for the provision of the residential care services in community-based houses including the recruitment and training of the carers and staff. Funding provided to CSOs is based on annual unit placement prices which, in relation to home-based care, ranged for 2011-12 from \$13,758 per child for general home-based care placements to \$27,515 per year for complex home-based care placements. For residential care, the annual placement unit prices ranged from \$152,642 to \$218,484 per child or young person;
- Direct fortnightly reimbursements to approved foster, kinship and permanent carers to contribute to household expenses. The reimbursements to foster carers are based on the three levels of foster care provision (general, intensive and complex), according to the age of the client and on the complexity of the child's needs. Where a child is placed in kinship or permanent care through child protection involvement, carers are eligible for reimbursement per child at the foster care general rate. In addition, carers receive a range of additional subsidy payments such as the new placement loading, education assistance initiative, education and medical assistance. The 2011-12 annual foster caregiver rates, which exclude the new placement loading range and vary by age, range for children aged 8 to 10 years from \$7,134 per child for general home-based care to \$35,360 per child for complex and high risk home-based care; and
- Flexible client support funds allocated to DHS regions for one-off expenses and case specific supports and client expenses for children and young people generally placed in out-of-home care. Placement and client expenditure is decided on a case-by-case basis and total annual expenditure is around \$40 million.

Standards and monitoring

Alongside the service framework and funding arrangements, DHS has developed, oversees and conducts a range of registration, accreditation and monitoring processes to underpin the quality of the out-of-home care placement system.

These arrangements include the CYF Act requirements that all CSOs providing out-of-home care, community-based child and family services and other prescribed services are to be registered. The standards that CSOs have to meet in order to maintain their registration status were developed and gazetted in April 2007 aim to:

- Ensure consistency in quality of out-of-home care;
- Set an organisational framework to help organisations to provide quality services for children, youth and families by enabling services to monitor and review performance on an ongoing basis;
- Help ensure organisations provide culturally competent services;
- Define the standards of care and support that children, youth and families can expect; and

- Where possible, use other accreditation processes as evidence of meeting the organisational component of the registration standards.

In order to show they meet the standards, agencies are required to complete two internal self-assessments and undertake one external review in every three year cycle.

On 22 June 2011 the Minister for Community Services released new DHS standards that will apply from July 2012 and will replace, among other standards, the *Registration Standards for Community Service Organisations*. These integrated standards are designed to ensure consistent quality of service across disability, homelessness and child, youth and family services and cover the areas of empowerment, access and engagement, wellbeing and participation.

Part 3.4 of the CYF Act sets out the broad legislative framework for approving foster carers and approving or engaging carers. In Victoria, CSOs providing foster care are responsible for the screening checks, assessment, approval and training process of people interested in becoming foster carers. The process from the perspective of potential foster carers involves:

- Participating in an information session;
- Lodging an official application form, including life history and screening check forms (police, Working with Children, medical and referee checks);
- Participating in the CSO's assessment and pre-service training (the assessment includes a home and environment check and interviews); and
- Gaining approval, which is granted for 12 months and reviewed every year.

The assessment of kinship carers is undertaken by DHS and varies from the foster care assessment in that the assessment of the carer is specific to their appropriateness as a carer for a particular child. The initial process involves:

- A preliminary screening prior to placement involving criminal record checks; checks on the suitability and fitness of the proposed carer; checks on whether any member of the household has been a client of statutory child protection;
- Discussions with the carer on safety and cooperation with DHS; and
- For a child under two years discussion on SIDS factors and safe sleeping arrangements.

Subsequently, further assessments are required within the first week of placement and within six weeks of the commencement of placement where the planned placement is likely to exceed three weeks.

As a check on the quality of care in out-of-home care placements, DHS commenced annual data collections in 2006-07 on allegations of abuse in care or quality of care for children and young people in out-of-home care. These data collections paralleled the development by the DHS in 2007 of draft *Guidelines for responding to quality of care concerns in out-of-home care*.

The guidelines, which were finalised in March 2011, specify that all allegations of possible physical or sexual abuse, neglect or other quality of care concerns must initially be screened by DHS in consultation with the responsible CSO to determine the exact nature of the concern and the most appropriate response. At the conclusion of a quality of concern investigation involving an allegation of abuse and neglect, DHS must determine whether the concern is substantiated or not substantiated. If the investigation identifies serious issues in relation to the carer's capacity to provide an appropriate standard of care, a formal care review may be initiated, even when the specific allegations have not been substantiated. To date, DHS has prepared four annual analyses of this quality of care data under four headings: allegations of abuse; completed investigations of possible abuse in care; quality of care reviews commenced; and completed quality of care reviews and outcomes.

Also relevant to the monitoring and improving of the quality of care are the activities of the Office of Child Safety Commissioner established in December 2004. The powers of the Child Safety Commissioner are outlined in the *Child Wellbeing and Safety Act 2005* and in relation to children in out-of-home care are:

- Promoting the active participation of those children in the making of decisions that affect them;
- Advising the Minister for Community Services and Secretary on the performance of out-of-home care services; and
- At the request of the Minister for Community Services, investigating and reporting on the out-of-home care service.

As part of these activities, the Child Safety Commissioner has developed the *Charter for Children in Out-of-Home Care* with the CREATE Foundation and undertaken activities in conjunction with relevant out-of-home care organisations, including DHS, directed at improving the outcomes for children and young people who have contact with out-of-home care services. However, as outlined in the Child Safety Commissioner's annual reports, these activities in relation to the out-of-home care sector are relatively 'light touch' supportive activities.

In his submission to the Inquiry, the Child Safety Commissioner put forward proposals to enhance his capacity to robustly and proactively monitor the out-of-home care system (Office of the Child Safety Commissioner submission, p. 15). The activities of the Office of the Child Safety Commission are discussed more generally in Chapter 21.

The issue of standards for out-of-home care has also formed part of the work arising from the Council of Australian Governments' (COAG) initiative and agreement in 2009 – *Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009-2020*. This framework identified 12 priority projects including to develop and introduce ambitious national standards for out-of-home care. In 2011, the Department of Families, Housing, Community Services and Indigenous Affairs together with the National Framework Implementation Working Groups released *An Outline of National Standards for Out-of-Home Care*. The standards cover: health; education; care planning; connection to family; culture and community; transition from care; training and support for carers; belonging and identity; and safety, stability and security, and set out some 22 performance measures along with a schedule of national measurement and reporting arrangements.

10.3 An overview of Victoria's out-of-home care population

This section sets out a range of summary data on Victoria's out-of-home care population including an analysis of out-of-home care data provided to the Inquiry by DHS for the period 1994-95 to 2009-10.

10.3.1 Key features and recent trends

The key characteristics of the current out-of-home care population and system are:

- The overwhelming importance of kinship care, permanent care and foster care in out-of-home care placement arrangements. Of the 5,678 children and young people aged 0 to 17 years in out-of-home care at the end of June 2011:
 - 2,383 or 42 per cent were in kinship care;
 - 1,361 or 24 per cent were in permanent care;
 - 735 or 12.9 per cent were in foster care;
 - 671 or 11.8 per cent in other home-based care arrangements;
 - 496 or 8.7 per cent were in residential care; and
 - 32 or 0.6 per cent in independent living and non-standard care options.
- The children and young people in out-of-home care are spread across the main age groups. At the end of June 2011:
 - 21.8 per cent were less than 4 years of age (including 3.1 per cent under 1 year);
 - 26.8 per cent were 5 to 9 years;
 - 30.4 per cent were 10 to 14 years; and
 - 21 per cent were 15 to 17 years.
- During the year significant numbers enter and exit from care across all age-groups. In the 12 months to the end of June 2011, 37.1 per cent of those entering care were less than 4 years of age compared with 28.9 per cent of those exiting care:
 - 21.7 per cent of those entering care were 5 to 9 years of age compared with 21.9 per cent exiting care;
 - 27.2 per cent entering care were 10 to 14 years of age and exiting care 21.9 per cent; and
 - for 15 to 17 year olds, 14.0 per cent and 27.3 per cent.
- Significant proportions of children and young people who exited care during the year had care periods of less than 12 months. Of the 1,729 children who exited care in the 12 months to 30 June 2010 and who were in care for one month or longer:
 - 35.6 per cent had been in care from one month to six months; 16.4 per cent from six months to less than a year;
 - 18 per cent from 1 year to less than 2 years;
 - 16 per cent from 2 years to less than 5 years; and
 - 14 per cent 5 years or greater.
- In line with the major regional variations in the reports of alleged child abuse and neglect and substantiation rates of child abuse and neglect, there are significant regional differences in the key dimensions of the out-of-home care:
 - in 2009-10 in the Gippsland and Hume regions, about 10 children and young people aged 0 to 17 years per 1,000 children and young people in the region were admitted to out-of-home care, more than three times the proportions rate for the Eastern Metropolitan and Southern Metropolitan regions.
 - at the end of June 2010, the proportion of child and young people in out-of-home care per 1,000 ranged from 2.7 in the Eastern Metropolitan Region to 10.0 in Gippsland

- while the broad patterns of home-based and residential care were generally similar, at the end of June 2010 residential care placements ranged from 6 per cent of placements in the Grampians region to 12 per cent in the Hume region, and kinship care placements represented 28 per cent of placements in the Grampians region and 42 per cent of placements in the Gippsland region.

Figure 10.3 indicates: the number of children and young people (aged 0 to 17 years) in out-of-home care in Victoria at the end of June over the period 2001–2011; the number of children in out-of-home care who had at least one out-of-home care placement during the year including those in out-of-home care at the beginning of the year; and the number of children who exited care during the year.

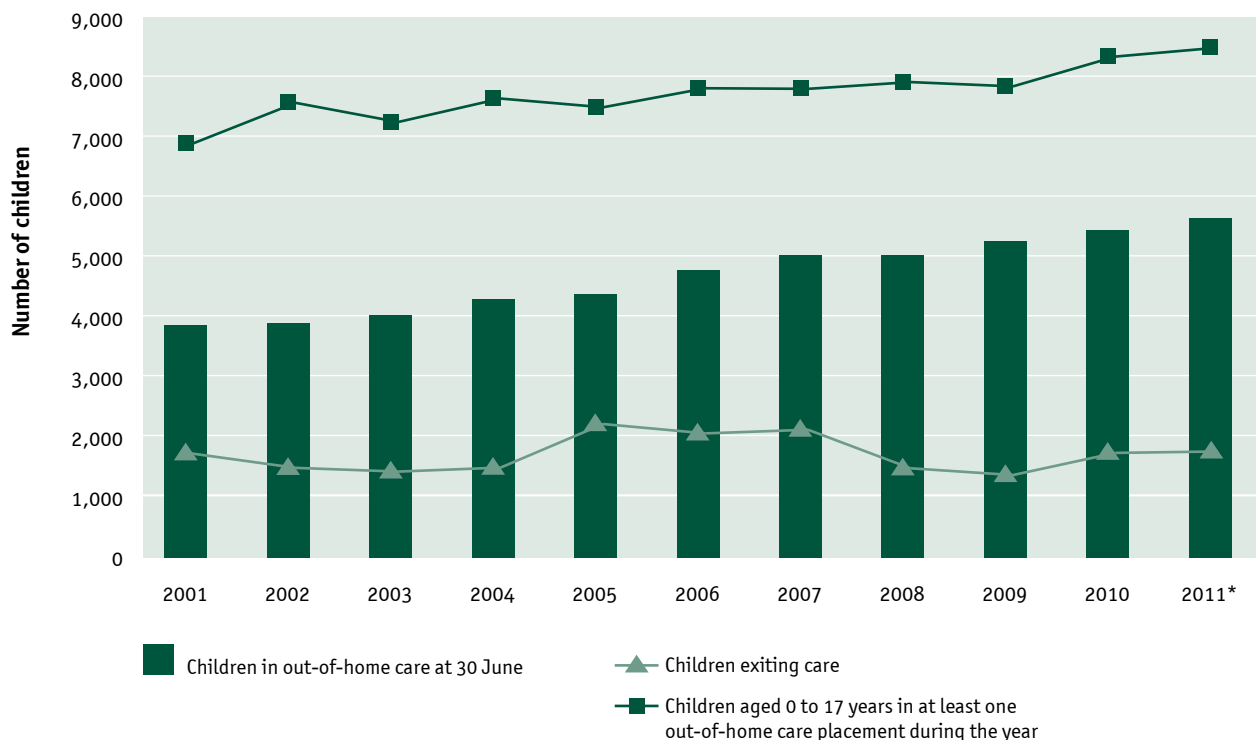
Over the 10 year period to June 2011, the number of children and young people in out-of-home care has increased by 46 per cent or an annual rate over 4 per cent. The rate per 1,000 children and young people aged 0 to 17 years in the population, which adjusts for population growth, increased from 3.4 to 4.6, an increase of nearly 35 per cent or over 3 per cent per annum. Over this period, the number of children in out-of-home care who had at least one placement during the year period increased by 23 per cent and, while the numbers who exited during the year fluctuated, there was little change in the annual number who exited over the period.

Consistent with these trends, the main driver of the increase in the number of children and young people in care in Victoria over the past decade has been the increase in the length of time spent in care. Figure 10.4 provides the percentage distribution of lengths of time in continuous care for children in out-of-home care at the end of June 2001 and 2011. Over this period the median duration of continuous time in care has increased from an estimated 16 months to over three years. As outlined in Section 10.3.2 the number of new entrants to out-of-home care in a given year has been declining over this period.

As outlined in Chapter 12, Aboriginal children and young people have markedly higher interactions with the statutory child protection system. In relation to out-of-home care, the headline observations are:

- Over the period of June 2001 to June 2011 the number of Aboriginal children and young people in out-of-home care increased by over 90 per cent with the rate per 1,000 Aboriginal children and young people increasing from 36.5 to 57.3, an increase of 57 per cent;
- Over the period the median duration of time in continuous out-of-home care increased from an estimated 15 months at the end of June 2001 to less than three years at the end of June 2011;

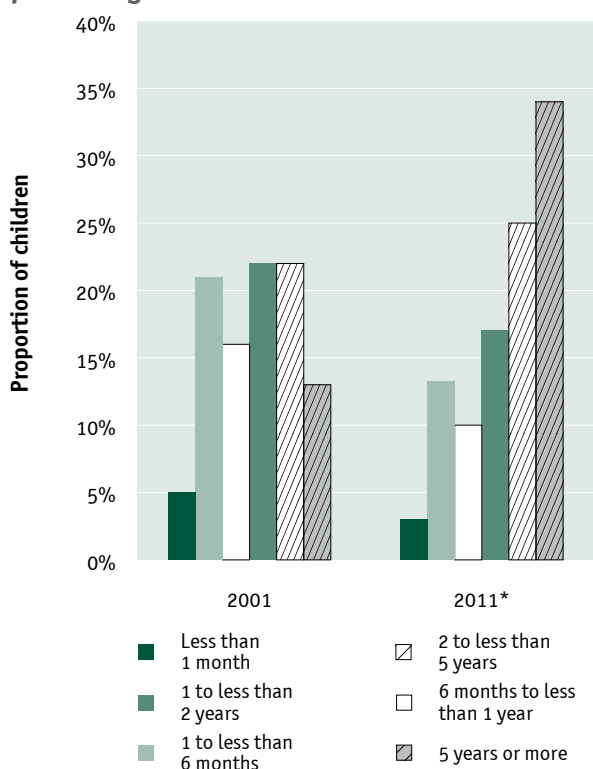
Figure 10.3 Children in out-of-home care, experiencing care and exiting care, Victoria, 2001–2011



Source: Steering Committee for the Review of Government Service Provision (SCRGSP) 2011c, Table 15A.57 and Table 15A.61, * provided to the Inquiry by DHS

- 93.2 per cent of Aboriginal children were in home-based care arrangements at the end of June 2011 with 51 per cent of Aboriginal children in kinship care;
- 64.4 per cent of Aboriginal children who entered care in the 12 months to the end of June 2011 were less than 10 years, a significantly higher proportion than for non-Aboriginal population; and
- Aboriginal children and young people who exited care in the 12 months to June 2011 had spent similar periods in care as non-Aboriginal children: 52.7 per cent had been in care for less than 12 months; 22.8 per cent one year to less than two years; and 24.5 per cent more than two years.

Figure 10.4 Children in out-of-home care at the end of June 2001 and 2011, by length of time in continuous care, Victoria: percentage distribution



Source: SCRGSP 2011c, Table 15A.60

* provided to the Inquiry by DHS

10.3.2 Victoria's out-of-home care system: a longer term perspective

DHS provided the Inquiry with a non-identifiable database of all out-of-home care placements since 1994-95. An analysis of this database provided further evidence of the significant changes over time in Victoria's out-of-home care population and the composition of out-of-home care placements.

Figure 10.5 sets out the age distribution of those entering out-of-home care in the four years 1994-95, 1999-00, 2004-05 and 2009-10. The major variation has been the sharp increase in the proportion of infants aged less than one year being placed in out-of-home care. In 1994-95, infants constituted around one in 14 of the children and young people placed in care; in 2009-10 this proportion had increased to more than one in eight being infants.

Figure 10.6 sets out the number of Aboriginal and non-Aboriginal children entering out-of-home care in the four years 1994-95, 1999-00, 2004-05 and 2009-10 and the proportion entering care who were Aboriginal. Over this period the proportion recorded as Aboriginal has increased from less than 6 per cent to over 16 per cent – or one in six Victorian children placed in out-of-home care.

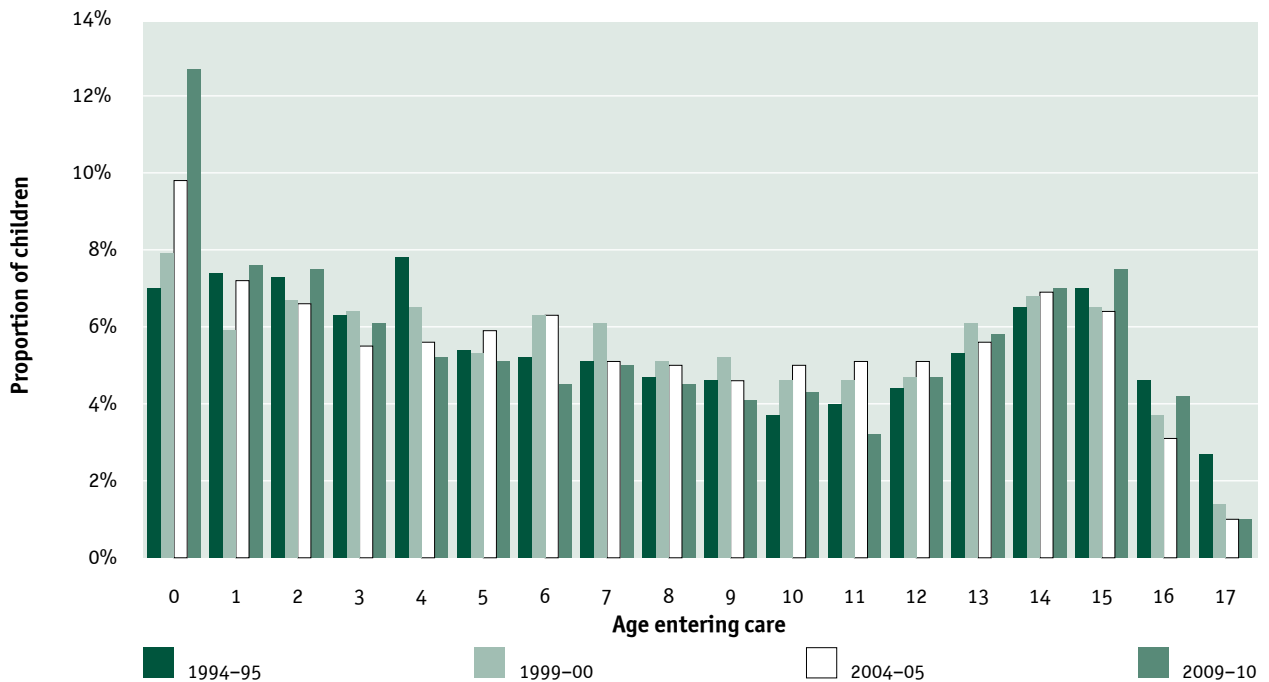
An analysis of children and young people entering non-respite care in 2009-10 indicated a significant proportion, over 30 per cent, had previously been admitted to care. The majority, around two-thirds, had one prior admission to care. For the remaining one-third, they were clustered around two and three prior admissions to care. The extent of re-admission to out-of-home care reflects the extent of resubstantiations for a number of Victoria's children and young people outlined in Chapter 9.

Over the past 15 years there has been significant change in the types of out-of-home care placements as illustrated in Figure 10.7. Most notably, the number of children and young people admitted to foster care placements, which have a shorter duration than kinship care and permanent care placements, has decreased from 3,731 in 1999-00 to 1,751 in 2009-10 – a decline of 53 per cent – while the number of children placed in kinship care has increased from less than 20 in 1994-95 to 1,211 in 2009-10. There was a decline in residential care placements from 668 in 1994-95 to 546 in 2009-10.

The increase in the duration of care outlined earlier has been evident across all age groups. Figure 10.8 indicates the proportion of children and young people exiting care in the selected four years whose length of time in care exceeded one year, by single year of age.

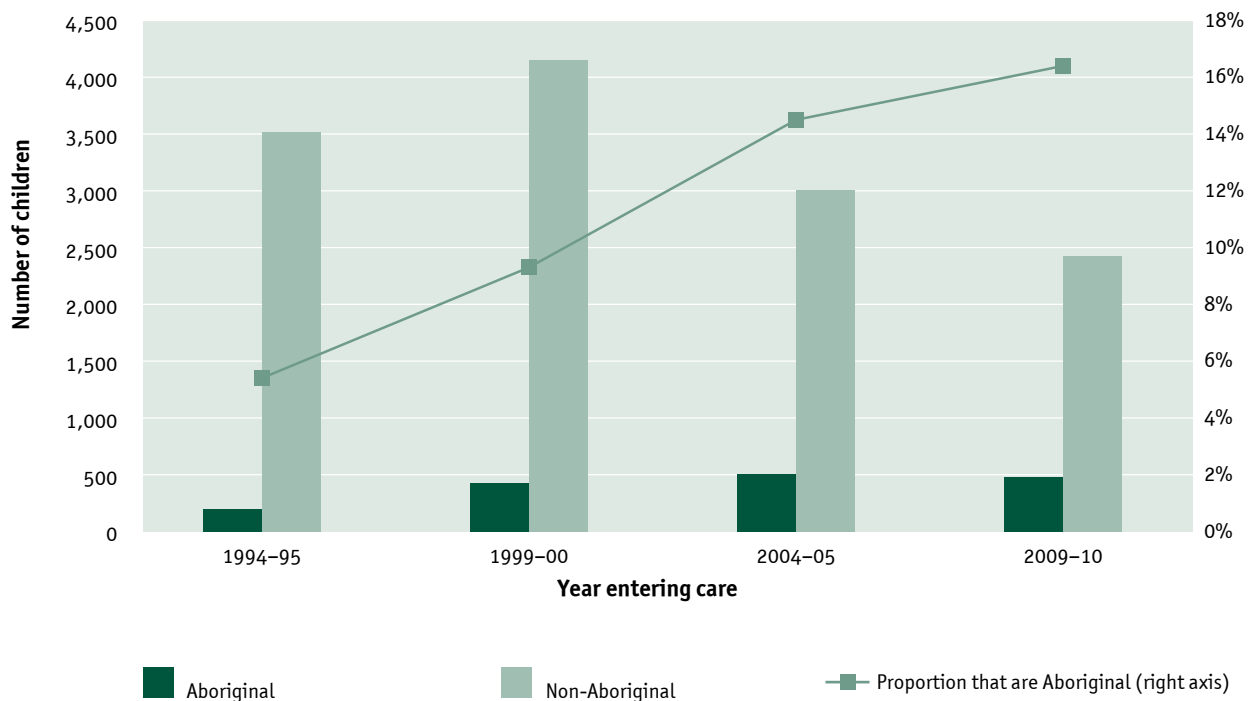
Figure 10.9 sets out the duration of out-of-home care for those who exited care in 2009-10 by their age at the time they entered care. The data relates to the last episode of placement in care (that is, previous placements in care are not included) and excludes respite placements. The average duration in care was nearly 18 months. Those who entered care at over 10 years of age tended to have lower durations of placement and those who entered care prior to age 10 years had longer durations.

Figure 10.5 Children admitted to out-of-home care, by age, Victoria, 1994-95 to 2009-10: Percentage distribution



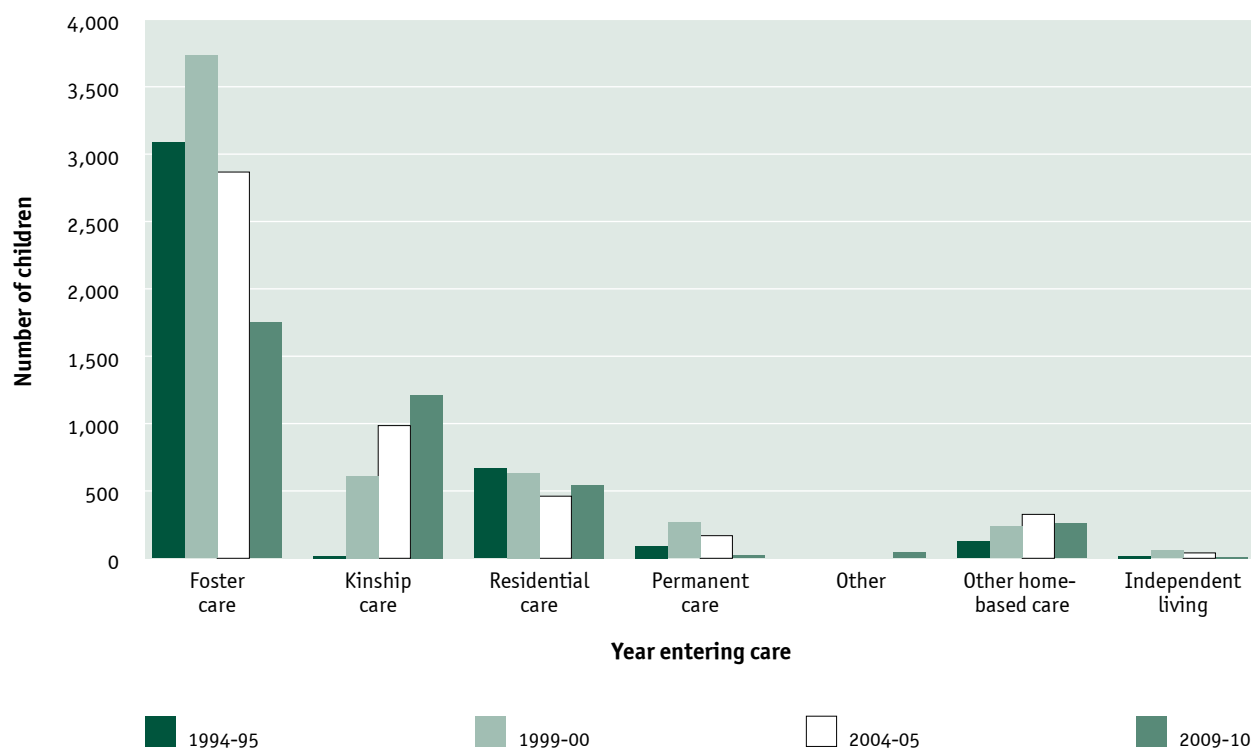
Source: Inquiry analysis of information provided to the Inquiry by DHS

Figure 10.6 Children entering out-of-home care, by Aboriginal status and proportion of Aboriginal children, Victoria, 1994-95 to 2009-10



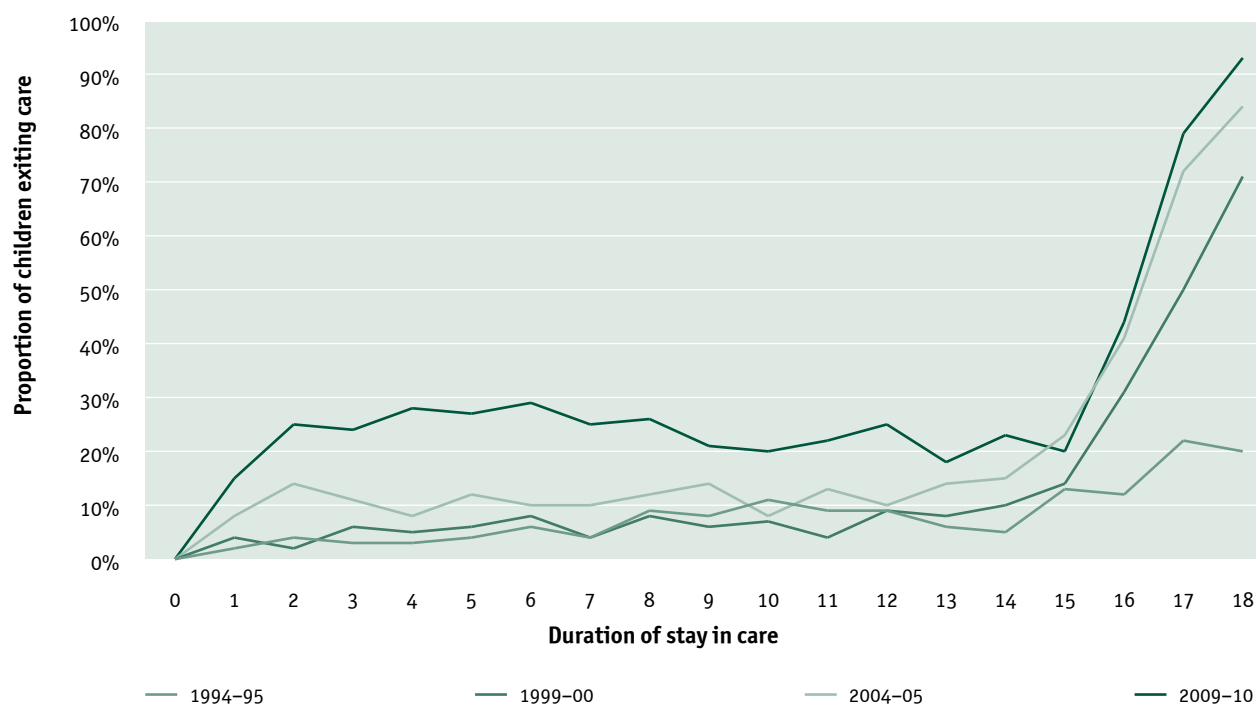
Source: Inquiry analysis of information provided to the Inquiry by DHS

Figure 10.7 Children admitted to out-of-home care, by type of care, Victoria, 1994-95 to 2009-10



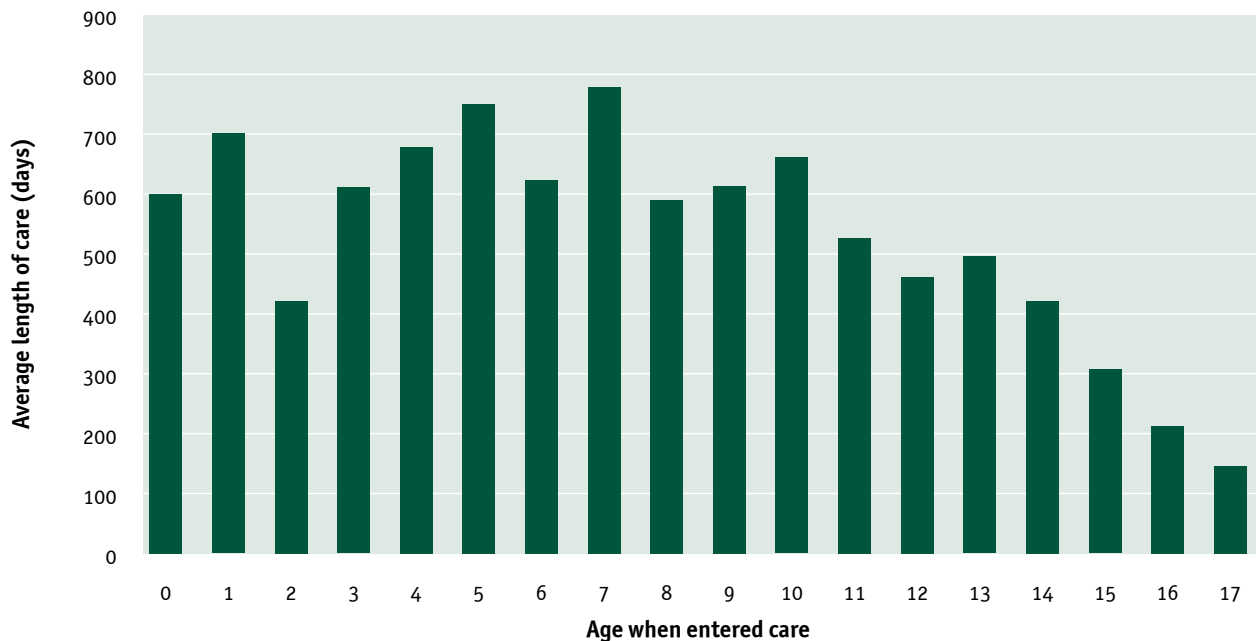
Source: Inquiry analysis of information provided to the Inquiry by DHS

Figure 10.8 Proportion of children exiting out-of-home care, with length of stay over one year, by age, Victoria, 1994-95 to 2009-10



Source: Inquiry analysis of information provided to the Inquiry by DHS

Figure 10.9 Children and young people exiting out-of-home care, by duration of care and age of entry into care, Victoria, 2009-10



Source: Inquiry analysis of information provided to the Inquiry by DHS

10.4 The performance of Victoria's out-of-home care system and key issues

As for many areas considered by the Inquiry, the absence of comprehensive data on the lifetime outcomes for children and young people placed in care prevents a definitive overall conclusion on the impact of out-of-home care placements for Victorian children and young people who are placed in out-of-home care. This is particularly so for young children who experience short periods of care.

However, for many children and young people currently in care, particularly those in residential care, the available information and evidence indicates the impacts of substantiated abuse and neglect and their prior family and socioeconomic circumstances are not being satisfactorily addressed by the out-of-home care system. The available and limited research on the 400 young people who leave care on the expiry of the guardianship or custody order, outlined in Chapter 11, also indicates a significant proportion experience homelessness, unemployment, financial difficulty, physical and mental health problems, drug and alcohol abuse, early parenthood and involvement in the criminal justice system.

In May 2010, the Victorian Ombudsman presented a report into out-of-home care to Parliament (Victoria Ombudsman 2010). A summary listing of the shortcomings in Victoria's out-of-home care system identified by the Ombudsman is presented in Chapter 4. The report also contained a number of recommendations designed to improve processes, increase scrutiny and introduce better planning into the out-of-home care system. This report has provided a backdrop to the analysis, conclusion and recommendations presented in this chapter.

This section presents a summary of the range of performance information available, the main areas highlighted in the submissions to the Inquiry and Public Sitings and identifies a range of key issues to be addressed.

10.4.1 Performance information

Published statistical information on the annual performance of Victoria's out-of-home care system is presented as part of the Government's annual Budget papers, the annual reports of DHS and, at a national level, in the COAG auspiced annual *Review of Government Services* and the regular families and children publications of the Australian Institute of Health and Welfare.

This data, along with specific data provided by DHS for the Inquiry, indicate that:

- In terms of the usage of out-of-home care, the proportion of Victorian children and young people in out-of-home care at the end of June 2010 – 4.4 children per 1,000 children aged 0 to 17 years – was significantly below the Australian average of 7.0 per 1,000 children aged 0 to 17 years and the lowest of any state or territory. The proportion of Indigenous children in care – 53.7 children per 1,000 children – was above the national average of 48.4 children per 1,000 children and above the rates of Queensland, Western Australia and South Australia.
- On relative expenditure, Victoria was recorded as expending, in 2009-10 dollars, an average of \$53,434 per child in out-of-home care in 2009-10, the third highest of all states and territories after the Northern Territory and Western Australia. However, as with rates of children and young people on out-of-home care, a range of factors including the policy and service framework and the broader demographic and social context impact on the comparability of this information;
- On the issue of safety of out-of-home care placement, 0.9 per cent of children in out-of-home care in Victoria in 2010-11 were the subject of a substantiation of harm or risk and the person responsible was living in the household at the time;
- On stability of placements in Victoria's out-of-home care system:
 - 21.9 per cent of children on a care and protection order and who exited care after less than 12 months in 2009-10 had had three or more placements;
 - 50.6 per cent of children on a care and protection order and who exited care after more than 12 months in 2009-10 had three or more placements in line with the overall proportion for Australia; and
 - 12 per cent of children and young people in care at the end of June 2010 had three placements or more in the previous 12 months (excluding placements at home).
- On the issue of age appropriate, sibling sensitive and Aboriginal placements:
 - 97.7 per cent of children under 12 years were in home-based care at the end of June 2011 and of the 2,654 siblings in care as at the end of July 2011, 1,924 or 72.5 per cent were placed with at least one sibling; and
 - at the end June 2010, 42.5 per cent of Aboriginal children in Victoria had been placed with a non-Indigenous family or in non-Aboriginal residential setting.

- On the retention and utilisation of foster carers, 226 households commenced foster care in 2010-11 and 291 exited foster care, and at the end of June 2011, 39 per cent of foster care households were caring for two or more children. At the end of June 2010 the number of individual foster carers was 1,798.

An important measure of the performance of the out-of-home care system are the stability of placements for children and young people, particularly for those children who require long-term placements. Stable placements assist in creating an environment that is conducive to addressing the impacts of child abuse and neglect and the emotional, social, educational and other needs of children and young people placed in out-of-home care.

Stability of placements has been a major and long-term issue for Victoria's out-of-home care system. In 2003 DHS as part of a review of home-based care, reported on the results of five-year cohort of children and young people placed in home-based care for the first time in 1997-98. Over the five years, 75 per cent of the cohort had more than one placement and nearly a third had four or more placement changes. The average number of weeks spent in each home-based care placements was 61 weeks (DHS 2003b, p. ix).

Finding 5

The available data indicates the stability of placements has declined significantly over the past decade.

- In 2001-02, 78.2 per cent of children who exited care during the year and were on care and protection orders had experienced two or fewer placements. For those exiting care after two years the proportion who experienced two or less placements was 73.9 per cent;
- In 2005-06, 72.0 per cent of children who exited care during the year and were on care and protection orders had experienced two or fewer placements. For those exiting care after two years the proportion had fallen to 48.7 per cent; and
- In 2010-11, the proportions had fallen to 60 per cent and 44.1 per cent.

As noted, there has been a significant decline in the proportion of foster care placements. This reflects, in part, the priority placed on and rapid increase in kinship placements. However, it also reflects the long-term and continued decline in households interested and available for foster care. The DHS 2003 review of home-based care found that the number of foster carers was falling with a decline of over 40 per cent in the number of new foster carers in the previous five years (DHS 2003b, pp. x-xi).

Finding 6

There has been a sustained net decline in the number of foster carers in Victoria and over the past two years, the number of households exiting foster care totalled 806 compared with 517 households commencing foster care.

This performance information covers a range of service provision dimensions that form and should form part of an effective out-of-home care system. Less readily available, are data on whether the placements and supports are addressing the impacts of abuse and neglect on individual children and young people and their development needs in key areas such as education, health and social and emotional development.

Young people's thoughts on home-based and residential care

In this regard, the consultation conducted by the CREATE Foundation for the Inquiry, while very limited in terms of the number of children and young people involved and the representativeness of the sample, provided a source of information and views from the perspective of the children and young people who had or were experiencing out-of-home care. The experiences, as reported by the participants in the consultations, differed significantly between home-based care and residential care.

For those young people who were or who had lived in a residential unit, their negative comments tended to revolve around this being more negative than any other out-of-home care placement (CREATE Foundation 2011, p. 10).

More importantly, the report found:

Overall the children who participated in the online survey believed they had not had a better life since coming into care. Half of them believed they were actually worse off and one-fifth believed things were much the same as they were before coming into care (CREATE Foundation, p. 32).

The needs, behaviour and experiences of children and young people in care

In 2008 the Australian Institute of Family Studies assembled and analysed data from the assessment and action records for children and young people in out-of-home care in Victoria prepared as part of the *Looking After Children* framework. This study, which covered approximately one-third of children in out-of-home care with placement support, found:

- 53 per cent of children and young people met only half their educational objectives;
- In terms of social presentation areas, little more than half (55 per cent) of children aged five years and over were able to appropriately adjust their behaviour in different social settings;
- On self-care skills, only 35.6 per cent of children and young people were assessed as being able to function independently at a level appropriate to their age and ability;
- On risky behaviour, 21 per cent of children aged 10 years and over had been cautioned or warned by the police, or charged with a criminal offence, within the previous six months;
- Only 52 per cent of children were receiving effective treatment for all persistent problems;
- Children in residential and related arrangements were nine times more likely than children in home-based care to have been cautioned or warned by the police or charged with criminal behaviour within the previous six months; and
- Children in home-based care were also approximately 12 times more likely to meet more than half of the family and social relationship objectives than children in residential care (Wise & Egger 2008, pp. 15-18).

Educational outcomes

For all young people, educational attainment levels at school are critical to successful transition to adulthood and positive lifestyles. DHS and DEECD have recently collaborated in assembling relevant data on the educational attendance and attainment of children and young people in out-of-home care compared with the all Victorian children and young people attending government schools.

The data for 2009 provided to the Inquiry indicated:

- In the early years of schooling (Prep to Year 6) the rate of absenteeism for children in out-of-home care is similar to the rate for all children attending government schools. Although the rate of absenteeism for all children increases in the later years of schooling, it increases much more for children in out-of-home care and overall children in out-of-home care have almost twice as many absences as the average;
- In relation to performance on the Victorian Essential Learning Standards, in reading, writing, listening and areas of mathematics, the incidence of students in out-of-home care performing below, or well below standards increases as the year level increases. For reading, writing and listening, the proportion of children in out-of-home care performing below, or well below standards increases from around five per cent in Prep, to between 40 per cent and 50 per cent in Year 10.

For mathematics, by Year 10 more than half of children in out-of-home care performed below, or well below standards in all of the areas tested;

- There is a considerable gap between the performance of out-of-home care students and the general (government school) student population in all of the areas tested. Figure 10.10 shows the proportion of children performing below or well below reading standards for out-of-home care students and the general student population. Although the proportion of the general student population performing below standards increases with education level, the proportion of out-of-home care students performing below standards increases at a greater rate. By Year 10, 23.7 per cent of the general student population performs below expectations in reading, while 41.1 per cent of students in out-of-home care performed below standards. Generally, regardless of year level, children in out-of-home care are about twice as likely to perform below standards at reading. This gap in the educational performance of children in out-of-home care is also evident in the data on the writing, listening and mathematical standards.

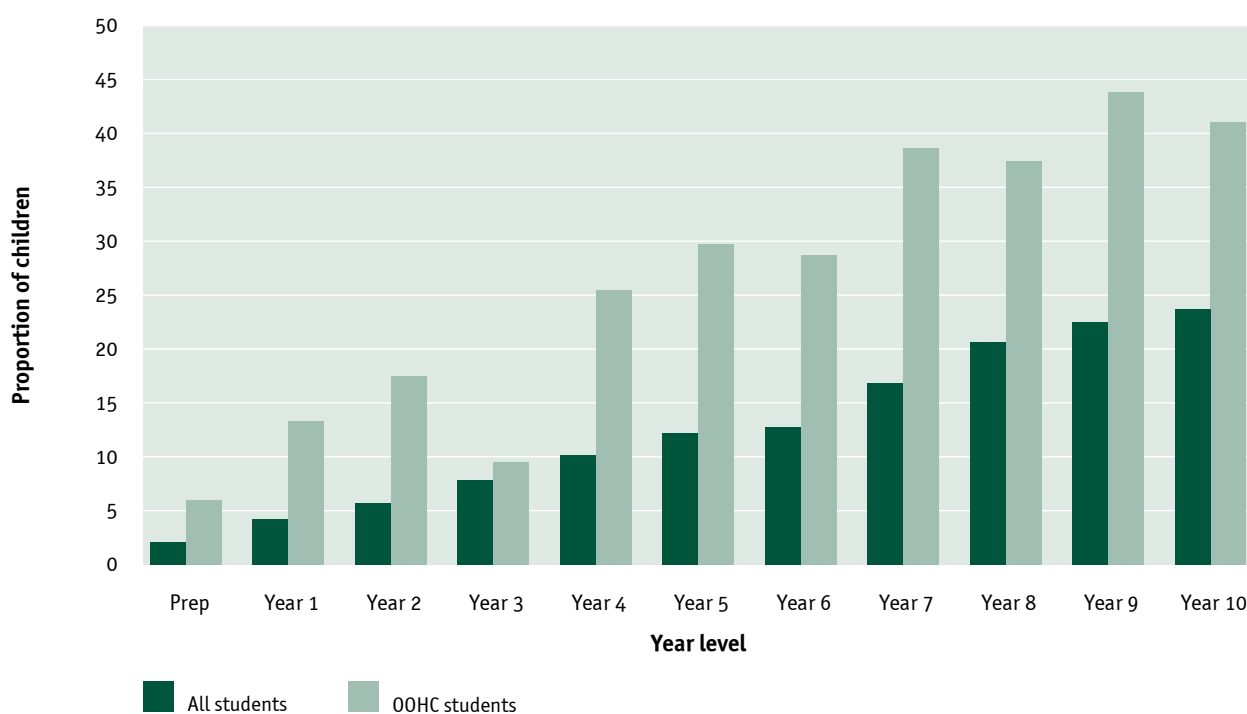
Allegations of abuse in care

As outlined in Section 10.2.3, DHS has established a registration, accreditation and monitoring framework covering the out-of-home care system. Included in these arrangements are the annual analyses of

allegations of abuse in care or quality of care for children and young people in out-of-home care and the conduct of quality of care reviews. The summary report prepared by DHS for 2009-10 outlined:

- There were allegations of possible abuse in care relating to 363 clients in out-of-home care and covering 279 reported incidents;
- Of the 363 allegations of possible abuse in care, 62 per cent related to physical assault and 15 per cent to sexual assault;
- Of the 363 allegations of possible abuse, 185 investigations were completed and the remainder were ongoing at the end of June 2010;
- Of the 185 completed investigations, 56 or 30.3 per cent were substantiated;
- 159 quality of care reviews were commenced in 2009-10, with the most significant issues of concern being inappropriate discipline (30.8 per cent), carer compliance with minimum standards (17.6 per cent) and inadequate supervision of the child (14.5 per cent); and
- Of the 159 quality of care reviews 86 were completed of which 63 or 75.3 per cent found there was evidence of quality of care concerns. Of those with quality of care concerns, 12 or 19 per cent resulted in the caregiver's approval being withdrawn (DHS 2011e).

Figure 10.10 Proportion of children and children in out-of-home care performing below or well below reading standards, Victoria, 2009



Source: Analysis of data provided to the Inquiry by DHS

Quality of out-of-home care providers

Information on the quality of out-of-home care was also gathered as part of the first external reviews by independent external reviewers of CSOs against the registration standards under the CYF Act. The registration standards apply to CSOs providing family services and out-of-home care services. The summary of these reviews reported:

- CSOs registered to provide family services only, tended to perform slightly better on governance type standards than those CSOs registered to provide out-of-home care services only; and
- The CSOs that provide out-of-home care services only and those that provide both out-of-home care and family services tended to perform slightly better on standards focusing on case management practice (DHS 2011n).

10.4.2 Inquiry submissions and Public Sittings

Victoria's out-of-home care system was a major focus of submissions and presentations to the Inquiry, particularly by CSOs. The issues raised covered the full spectrum from the overall service design and funding framework to the practical issues faced by foster and kinship carers in caring for and supporting some of the most vulnerable Victorian children and young people.

Need for major reform

Further to the observation by the Jesuit Social Services that '... out-of-home care for children and young people is not working adequately and, is indeed, at crisis point' set out in Chapter 5, the Joint submission of Anglicare Victoria, Berry Street, MacKillop, The Salvation Army, the Victorian Aboriginal Child Care Agency and the Centre for Excellence in Child and Family Welfare (Joint CSO submission) contained the following more detailed assessment:

The current arrangements for out-of-home care in Victoria have an historical basis that has led to the services struggling to cope with contemporary issues and growing demand. The models of care have largely been in place for decades, and they are models that are ill-equipped to manage the issues that children and young people bring with them. We need to re-think the types of out-of-home care that are provided, how they are provided and how they are funded. In particular we know that out-of-home care cannot deal with all the issues alone, and that we have to find ways of providing therapeutic responses for vulnerable children and young people in out-of-home care (Joint CSO submission, p. 59).

In their submission The Victorian Council of Social Services (VCOSS) put forward the view:

Systemic changes are required to improve out-of-home care, including better assessments, a better range of placement options (e.g. vocational as well as residential, professional foster care), more therapeutic resources, an improved funding model. More multidimensional and intensive supports, systemic linkages across service systems, and a system that continues to 'be a good parent' to young people after they leave care (VCOSS submission, p. 42).

Comprehensive assessments

The areas identified in the VCOSS submission were also the subject of focus and recommendations in many other submissions and presentations to the Inquiry. For example, on the issue of the need for comprehensive assessments of children and young people being placed in out-of-home care, the submission by the Take Two Partnership observed:

Issue: The policy emphasis at a national and statewide level regarding physical, social and emotional health assessments for children has not been translated into action.

Suggestion: There have been various pilots focussing on young children, first time into care and the current pilot being considered regarding children in residential care. The reality is that these children are of all ages and whether it is their first, second or forty-fifth placement – they need a brief health and wellbeing screening and response (Take Two Partnership submission, p. 7).

The Joint CSO submission recommended that comprehensive assessment approaches be established across Victoria to ensure appropriate holistic assessments are undertaken to fully inform decisions on the placements and specialised supports for children and young people (p. 61).

Flexible placement and support options

On the issue of the availability of suitable and flexible placement and support options, the two main matters raised in submissions were the pressures on maintaining the home-based care system and the constraints of the current care models and placement arrangements in addressing the individual needs of many children and young people placed in out-of-home care. The submission by St Luke's Anglicare outlined:

From St Luke's experience the home-based care system is under increasing pressure and its ability to meet current demand and provide the level of care required is severely compromised. We are experiencing real challenges in recruiting carers and maintaining a sufficient carer pool that can meet demand for new placements and offer the level of respite required for carers providing long term care

... Carer feedback highlights these challenges and many carers are concerned about the difficulties they face in caring for children and young people with very challenging behaviours due to past experiences of trauma ... St Luke's would seriously question whether the current structure and resourcing of home care allows for a viable program in the long term (St Luke's Anglicare submission, p. 19).

Professional foster care

Given the pressures on the home-based care system, a number of submissions supported the consideration and introduction of a professional carer model to be run in conjunction with current home-based care. The Joint CSO submission went further with an all-embracing recommendation:

That foster care is professionalised by paying foster carers an annual salary with all the usual conditions that apply for Australian workers, such as superannuation, annual leave and long service leave. Foster care arrangements would be additional to the salary paid, and would be paid for the number and length of foster care placements provided (Joint CSO submission, p. 64).

Care options

The constraints of placement availability and the range of care options were highlighted in a number of submissions. For example, MacKillop Family Services observed:

Too often in placement decision making the best interests of children and young people are subordinate to the pragmatics of placement availability. There is a clear need to expand the suite of available care options for children not able to live with their parents (MacKillop Family Services submission, p. 8).

The limited range of care options was identified as a major issue in meeting the needs of children and young people with a disability and children and young people with sexually abusive behaviour. The current design of residential care was also identified by many submissions as facing major challenges. The St Luke's Anglicare submission observed:

Serious challenges continue with the delivery of Residential Care programs. The needs and behaviours of the young people placed in residential care considerably stretch the capacity of the program to provide the required response to meet the needs of the young people. Whilst a residential care model is absolutely necessary within the suite of out-of-home care services, it is St Luke's view that the current design of the residential care model is severely limited and it struggles to meet the desired outcomes (St Luke's Anglicare submission, p. 19).

Therapeutic care

A major theme of many submissions was to embed therapeutic responses across all forms of out-of-home care building on the selective trialling of therapeutic care and supports across the home-based and residential care options. A therapeutic response is generally defined as one that responds to the complex issues of abuse and neglect, and seeks to address concerning issues and behaviours exhibited by the child or young person. MacKillop Family Services commented;

The Victorian system is in danger of re-traumatising children and young people due to lack of responsiveness to their needs ...

All children and young people removed from their family and placed in out-of-home care will have experienced trauma and will require a therapeutic care response (MacKillop Family Services submission, p. 8).

New funding arrangements

These criticisms of the current range of placement options and services were generally linked to observations about the current adequacy and structure of funding including allowance for the inevitable variations in the overall level and composition of out-of-home placement requirements. In particular, the resort to contingency placements was viewed as not only an indication of the need for additional placement and funding capacity but the growing need to develop more flexible and specialised arrangements. A system of client-based funding predicated on the assessed needs of children and young people was proposed by the Joint CSO submission which argues:

Such client-based or person-centred approaches are already in place in Victoria in the ageing, disability and home care sectors, and the experiences of these sectors provides insight into the effectiveness of alternative and tailored responses. A person-centred approach allocates resources more strategically by allowing individually tailored responses to be developed, it also allows resources to be distributed transparently and more equitably, it encourages consideration of options and flexibility, and it can involve the service recipient in the decision making about how the service system supports them (Joint CSO submission, p. 60).

Improved coordination and information exchange

The range and respective interests of parties involved in the out-of-home care system – DHS, the Children's Court, CSOs, foster, kinship and permanent carers and the families of children and young people – was reflected in the focus in many submissions on the

need for better coordination and information and, more significantly, greater clarity in the roles and responsibilities of the various parties. The range of views expressed covered:

... the decisions about where to place a child or young person ... should be a joint responsibility between the community services sector and the statutory child protection system ... this change would strengthen local decision making and integrate it more closely with those responsible for service delivery (Joint CSO submission, p. 61).

In Berry Street's experience, the interests of children and young people are best served where the case management function is contracted to Community Service Organisations (CSOs). CSOs are best placed to engage with and maintain strong relationships with children and young people and working through care teams and other mechanisms advocate for their best interests (Berry Street submission, p. 30).

Alongside the need to reform case management by contracting this function to CSOs there is a need to review, simplify and integrate the overlapping case planning and client information management systems monitoring systems. At present the system is literally awash with well-intended but overlapping requirements for the development and completion of plans for individual children and young people ... Current planning and client information tools that require review and integration include, but are not limited to the following:

- Best Interest Plans;
- Stability Plans;
- Education Support Plans;
- Case Management Plans;
- Care Management Plans;
- Cultural Support Plans;
- Leaving Care Plans;
- CRIS/CRISP; and
- Looking After Children (LAC) (Berry Street submission, p. 30).

Strengthening the Care Team Model and LAC framework to ensure carers have necessary information on the children they care for, carers views are heard and respected in planning and important outcomes for children in care are achieved (Foster Care Association of Victoria submission, p. 1).

In addition to these broad systemic comments on the provision of out-of-home care in Victoria, three specific areas were highlighted in submissions as presenting barriers and inhibiting good outcomes from the out-of-home care system: the level of care reimbursements and access to additional financial support for significant expenses and addressing specific issues; supports for kinship carers and access

to continued supports for permanent carers; and the disengagement from school of children and young people in out-of-home care.

Carer reimbursements

On carer reimbursements, The Salvation Army argued:

The level of reimbursement to foster carers urgently needs to be reviewed. We are placing increasing demands on foster carers in terms of complexity of children and young people that they are required to care for and the associated requirements of their role; however this is not reflected in the level of reimbursement that foster carers receive (The Salvation Army submission, p. 18).

At the Melbourne Public Hearing, Ms C, a foster and permanent carer for a sibling group of four, commented on the level of foster care reimbursements in the following terms:

It's very expensive to be a carer in Victoria. Our carer reimbursements are among the lowest in Australia, yet we are expected to do more and more with these...
... Foster care is the only volunteering which is 24 hours a day, seven days a week and where you are also required to spend your own money in the role of volunteering. It's a bit like working for free and then paying the community some money each day to be able to keep doing it.

As outlined in Section 10.2.3 DHS provides additional financial support to carers for significant one-off expenses. The funding coverage and guidelines and the consistency of access across the out-of-home care system was the subject of comment by caregivers and their representatives. The supplementary submission by the Foster Care Association of Victoria commented on the need for 'consistency across all placements/regions in terms of what extra reimbursements and entitlements are available for carers (Foster Care Association of Victoria supplementary submission, p. 7). The supplementary submission by Upper Murray Family Care provided practical examples of how the procedures and absence of transparency about the coverage of these additional funds can inhibit the timely provision of specialist health services (Upper Murray Family Care supplementary submission). These examples included approval for urgent speech therapy for a five year old boy and dental treatment for a 12 year old boy who had been in need of dental work for around three years.

Support for kinship carers

The rapid growth in kinship care in advance of detailed consideration of the specific support requirements of kinship carers was area highlighted in the submissions from Grandparents Victoria, and Kinship Carers Victoria and Humphreys and Kiraly.

The rapid growth in kinship care has led to ad hoc development of support strategies. There are three strategies GPV/KCV commends as being both urgent and important:

- Training for and about kinship care;
- Helping kinship carers to help themselves; and
- Education of children in out-of-home care (Grandparents Victoria and Kinship Carers Victoria submission, p. 11).

Kinship care is a discrete and unique form of care that is qualitatively different from foster care. Kinship care support requires its own model, skill set and training ... Support for kinship care placements, both 'temporary' and 'permanent' needs to be as great or greater than foster care, to ensure children and carers' safety and wellbeing (Humphreys & Kiraly submission (b), p. 2).

Ongoing support for permanent carers

Linked to the issue of support for kinship carers, was the observation in many submissions of the need for ongoing support to families once a child has been placed in permanent care.

... the withdrawal of care management and financial support to families once a child has been placed in Permanent Care (whether originally foster carers or kinship carers), a legislative option that is intended to secure the long term care and connection with a family for children, has led to many breakdowns in the care arrangements. We strongly believe that families who commit to providing Permanent Care opportunities continue to deserve the support of the Care System and that the young people placed in Permanent Care have a right to continue to be supported by a wider support network (The Salvation Army submission, p. 21).

Improved educational engagement

A number of submissions put forward proposals to address the lack of engagement in the educational system and poor levels of educational attainment of many children in out-of-home care. St Luke's Anglicare and Berry Street respectively recommended:

That DHS and DEECD in partnership with out-of-home care agencies develop a well-funded model of alternative learning settings for young people who cannot be maintained in mainstream education (St Luke's Anglicare submission, p. 23).

That the State Government recognise, support and develop a range of alternative settings for the delivery of primary and secondary education for children and young people in OOHC for whom mainstream settings are not viable (Berry Street submission, p. 18).

Other submissions placed emphasis on providing additional supports and educational programs and strategies to maintain the links to the mainstream education system. Anglicare Victoria recommended:

Increase provision of teacher training and resources in both initial and continuing teacher education to assist teachers to respond to trauma-related behaviour.

Improve the scale and reach of targeted education supports and alternative education programs for children/young people across the age range whose learning is disrupted by the effects of trauma

Implement a system to ensure that children/young people who drop out of school and cease to be enrolled can be identified and located, and strategies put in place to secure their re-engagement in education (Anglicare Victoria submission, p. 35).

Records

A small number of submissions raised the general issue of support for archiving and record-keeping in Victoria's out-of-home care system. Two main perspectives were identified. MacKillop Family Services drew attention to their Heritage and Information Service established to assist people who spent time in institutional care or were placed in foster care by any of these institutions access their records. The submission emphasised:

Information collected and the records that are maintained for children and young people growing up in care must be securely stored and able to be accessed at a later date. This material is often an enduring source of identity for children and young people who grew up in care and agencies should be resourced to ensure that this material is collected, stored and released appropriately (MacKillop Family Services submission, p. 17).

The Humphreys, et al submission (b) reported on the project examining the role played by records and archives in the health, wellbeing and identity construction of young people in care and of adults who were in care as children. The project is funded by the Australian Research Council and a wide range of CSOs, together with organisations representing the interests of the care population. DHS is also a project partner.

The submission contains a number of recommendations focused on: the current state of record-keeping; the complexity and current fragmentation of a child's record; collaborative recording; identity documents; the records continuum; and access to records. The underlying tenet of the submission and recommendations is to balance the focus of practitioners on the current needs of children and young people in care with an increased awareness of their longer term identity needs.

Recommendation 24

The Department of Human Services and community service organisations should continue to support the Who Am I Project on out-of-home care record-keeping to enable children and young people to access all records of relevance and, as appropriate, be provided with a personal record when leaving care.

10.5 Conclusion

The structure and performance of Victoria's out-of-home care system has been the focus of three major DHS sponsored or led policy reviews and reports over the past decade: *Public Parenting: A Review of Home-Based Care in Victoria* (DHS 2003b); *Family and Placement Services Sector Development Plan* (DHS 2006b); and *Directions for Out-of-Home Care* (DHS 2009a). In addition, in May 2010 the Victorian Ombudsman produced the report of his *Own motion investigation into Child Protection – out-of-home care*.

The policy reviews and recommendations covered a range of varying issues but with significant commonality in the areas emphasised and the strategies recommended. *Public Parenting* identified the following directions for reform:

- Focus on prevention;
- More responsive service models;
- Comprehensive assessment;
- Quality assurance;
- A professional foster care service;
- More appropriate service delivery of kinship care;
- Development of a new flexible funding model; and
- Communication.

The *Family and Placement Services Sector Development Plan* prepared by representatives from CSOs, peak bodies, community health, local government and DHS outlined a detailed action plan focused on strengthening:

- Advisory structures and planning;
- The focus on outcomes;
- The voice of children, young people and families;
- Aboriginal service responsiveness;
- Foster care;
- Service model effectiveness and quality;
- Service sustainability;
- Workforce; and
- Profile.

The *Directions for Out-Of-Home Care* released in 2009 outlined seven reform directions:

- Support children to remain at home with their families;
- A better choice of care placement;
- Promote wellbeing;
- Prepare young people who are leaving care to make the transition to adult life;
- Improve the education of children in care; and
- Develop effective and culturally appropriate responses for the high numbers of Aboriginal children in care; and
- A child-focused system and processes.

These directions formed the basis for initiatives in the 2009-10 State Budget to expand the number and quality of out-of-home care placements, extend the therapeutic residential care pilot program and assist Aboriginal kinship carers to better meet the specific needs of Indigenous children.

The 2011-12 State Budget included a package of initiatives covering health and education assessments for young people entering residential care; enhanced placement capacity and care arrangements including responding to out-of-home care shortages; increased support for foster carers; and initiating a long-term study assessing the impact of out-of-home care on children.

Many of these themes identified in these three major reviews and reflected in the initiatives in recent budgets, were also the subject of comment and recommendations in the submissions. In addition, these reviews as with the submissions considered a wide range of out-of-home care issues in significant detail.

In the Inquiry's view, these reviews, submissions and the supporting material, provide important detail on which to develop a comprehensive future strategy for Victoria's out-of-home care system.

However, the Inquiry considers an important missing link in the reviews and responses to date, has been the absence of an explicit goal for the scale and key dimensions of Victoria's out-of-home care population. More specifically, the growth of four per cent annually in the out-of-home care population appears to have resulted in the annual budget initiatives addressing past capacity and quality concerns and not being premised on a goal and accompanying strategies for the future dimensions of the out-of-home care population. If Victoria's out-of-home population increases at the same rate over the next three decades as it has past decade then more than one per cent of Victorian children and young people will be in out-of-home care at any point in time and a considerably higher proportion will have experienced an out-of-home care placement.

Adopting this forward looking view is particularly important because when benchmarked against the:

- Objectives and responsibilities in the CYF Act that the Secretary of DHS 'must make provision for the physical, intellectual, emotional and spiritual development of the child in the same way a good parent would' (section 174); and
- The overall objective of the Inquiry's Terms of Reference to reduce 'the negative impact of child neglect and abuse in Victoria'. It is clear that there

are major and unacceptable shortcomings for many children and young people placed in out-of-home care in Victoria, and addressing these deficiencies requires sustained long term strategies and funding.

The Inquiry considers these quality of care concerns and outcomes reflect and are being exacerbated by:

- The continued growth in the proportion of Victorian children in out-of-home care particularly Aboriginal children and significant regional variations in the placement of children and young people in out-of-home care;
- Resource and other constraints on planning and providing comprehensive and flexible models of care and support driven by the individual and significant needs of children and young people placed in out-of-home care and their families;
- The absence of a contemporary, integrated and viable framework for home-based care given the demographic changes impacting on foster care and the increasing reliance on kinship care;
- Major shortcomings in the safety, quality and outcomes from residential-based care; and
- Limitations in the current governance, responsibility and accountability frameworks and the structure and performance of CSOs.

Recommendation 25

The Government should, as a matter of priority, establish a comprehensive five year plan for Victoria's out-of-home care system based on the goal, over time, of the growth in the number of Victorian children and young people in care being in line with the overall growth in Victorian children and young people and the objective of improving the stability, quality and outcomes of out-of-home care placements.

The key elements of the plan should include:

- Significant expansion in placement prevention initiatives to divert children from out-of-home care. In particular, increased investment in placement diversion and re-unification initiatives, when the safety of the child has been professionally assessed, involving intensive and in-home family support and other services for key groups such as families of first-time infants and young children;
- More timely permanent care where reunification is not viable;
- All children and young people entering out-of-home care undergo comprehensive health, wellbeing and education assessments;
- All children in out-of-home care receive appropriate therapeutic care, education and other services;

- Progressive adoption of client-based funding to facilitate the development of individual and innovative responses to the needs of child and young people who have been the subject of abuse and neglect;
- The introduction over time of a professional carer model to provide an improved and sustained support for children and young people with a focus on lowering the use of residential care;
- Significant investment in the funding and support arrangements for:
 - home-based care including a common service and funding approach across foster care, kinship and permanent care and improved carer training, support and advocacy arrangements;
 - residential care including mandating training and skill requirements for residential and other salaried care workers (i.e. the proposed professional care model); and
- The adoption of an area-based approach to the planning, delivery and monitoring of out-of-home care services and outcomes involving the Department of Human Services, community service organisations and other relevant agencies.

Given the underlying trends and quality issues, implementation of this plan will require significant investment.

The available data indicates that a significant proportion of children and young people placed in out-of-home care for relatively short periods and the majority exited care within one to two years. A focus on placement prevention and keeping infants, children and young people with their families through intensive family support arrangements would reduce many of these placements, avoid the inevitable disruption to family relationships and enable a clearer focus on quality longer term placements. The initial evidence on the Family Coaching pilots referred to in Section 10.2 illustrates the potential of collaborative approaches, clear targeting and whole-of-family approach to placement prevention.

If the out-of-home care system is to effectively and flexibly respond to the individual needs of children and young people, then the adoption of comprehensive assessments and client-based funding arrangements are clearly required. In relation to assessments, steps have already been taken to introduce assessments for young people entering residential care. Client assessments are the first step in aligning services to needs, and moving towards client funding will facilitate services being aligned to needs.

The experiences in other sectors, for example, disability, indicates the introduction of client-based funding is a detailed but achievable task covering service specification and costing, service provider consultation and funding and monitoring arrangements.

The out-of-home care system has a complex array of service types, funding levels and funding arrangements. Funding levels differ significantly across the various types of home-based care. An essential prerequisite to the introduction of client-based funding is the specification of the desired service requirements for out-of-home care placements including provision of specialist health, counselling, education and developmental services. This consideration will enable areas such as therapeutic care and specialist counselling and specialist educational support to be transparently included as key elements of the generic placement and support arrangements. The scope and coverage of caregiver reimbursements would also need to be clarified as part of this consideration.

Accompanying the specification of service scope is the requirement for determination of the appropriate service price and funding levels. This determination will provide the opportunity to:

- Develop and adopt a common service and funding framework across all forms of home-based care;
- Move towards a component of professional care to enable flexible and specialist home-based arrangements for high-needs children and young people to be developed as an alternative to residential care placements; and
- Significantly up-grade the expectations and skill requirements of residential carers.

Recommendation 26

To provide for the clear and transparent development of a client-based funding, the Government should request the Essential Services Commission to advise on:

- The design of a client-based funding approach for out-of-home care in Victoria; and
- The unit funding of services for children and young people placed in care.

On the specific issue of the introduction of a professional care model, the Inquiry is aware that a number of impediments to the potential utilisation of professional carers by CSOs and to the recent agreement of federal, state and territory community and disability services ministers to consider professionalisation of foster care, as part of the second three-year action plan under the *National Framework for Protecting Victoria's Children*. However, it is important that Victoria begins the process of adapting to an out-of-home care system where foster carers become increasingly scarce and where the models of residential care for young people are increasingly complemented by intensive home-based arrangements.

The development of the professional care model, to be effective, will require the development of a new category of worker along with the detailed consideration and design of a whole suite of underpinning and related arrangements covering such issues as occupational health and safety and the possible consequences for the other models of home-based care. Over the past decade, the establishment of professional care has been periodically attempted and the Inquiry considers the introduction of professional foster care is long overdue.

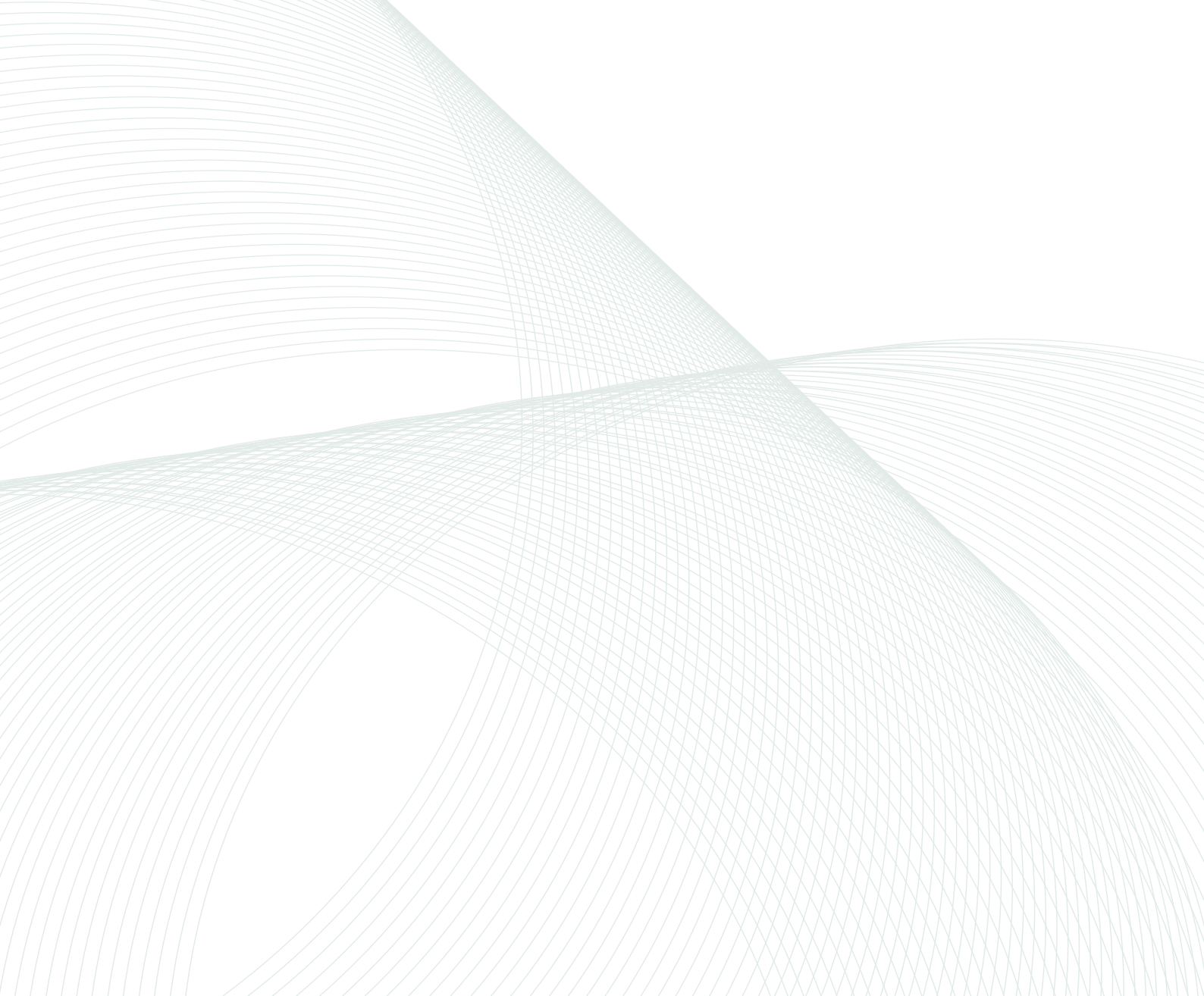
Recommendation 27

The Victorian Government should, as a matter of priority, give further detailed consideration to the professional carer model and associated arrangements and request that the Commonwealth Government address and resolve, as a matter of priority, significant national barriers associated with establishing this new category of worker including industrial relations and taxation arrangements.

Victoria's out-of-home care system represents a significant activity for some 40 CSOs, more than 5,000 carers and large numbers of child protection workers who interact on a wide range of issues. Effective interaction and collaboration between all parties is essential to outcomes and experiences of children and young people in care. Chapter 9 has outlined the development of an area-based and integrated approach to vulnerable families and child protection service.

Given the major changes proposed for the future provision of out-of-home care, including the greater emphasis on placement prevention and intensive family support, it is recommended that adoption of this area framework be expanded to include out-of-home care services and supports. In particular, it is proposed that an area-based approach be adopted to the planning, delivery and monitoring of out-of-home care services and outcomes involving DHS, CSOs and other relevant agencies. Importantly, it facilitates a structure of out-of-home care more closely aligned to the area characteristics and needs rather than historical provision.

This area-based approach, when coupled with the overall out-of-home care objectives and targets and the proposed transition to client-based funding, will also facilitate consideration of the desired range of placement services and specialist supports and, in turn, the expectations and requirements of CSOs. Chapter 17 considers these implications in further detail.



Part 4: Major protective system elements

Chapter 11:

The experiences of children and young people
when leaving out-of-home care

Chapter 11: The experiences of children and young people when leaving out-of-home care

Key points

- The Inquiry was asked to investigate the quality, structure and functioning of out-of-home care including transitions and improvements to support better outcomes for children and families.
- Around 400 young people leave out-of-home care annually following the expiry of their guardianship or custody order. The limited evidence and research available suggests a significant proportion experience major issues in the transition to independent living and have long term negative life outcomes.
- The *Children, Youth and Families Act 2005* included for the first time a legislative responsibility for the Secretary of the Department of Human Services for the provision of transition and post-care services to assist the transition of young people under the age of 21 years to independent living.
- In recent years the Department of Human Services has developed and implemented specific leaving care and post-care services and programs and further funding was allocated in the 2011-12 Budget, including provision for the new Leaving Care Employment and Education Access Program.
- However, contemporary and comprehensive research and information on the experiences of Victorian young people leaving care and their access to, and impact of, leaving care and post-care services are not available.
- The limited research available suggests three factors are critical to achieve better post out-of-home care outcomes: improving the quality of care; a more gradual and flexible transition from care including access to stable accommodation arrangements; and more specialised after-care supports.
- A number of submissions to the Inquiry referred to the need for the legislative provisions to reflect the broader community trend where the majority of young people remain with their parents until their early 20s.
- The Inquiry makes a number of recommendations including:
 - the urgent need to gather information on current post-care experiences and the access to and impact of current arrangements;
 - the Secretary of the Department of Human Services should have the capacity to extend out-of-home care placements on a voluntary and needs basis to young people beyond 18 years;
 - enhancing current leaving care arrangements including stable initial accommodation arrangements and the level, range and integration of leaving care and post-care assistance; and
 - consideration in the medium-term of extending post-care assistance on a needs basis to the age of 25 years.

11.1 Introduction

In Victoria during 2010-11, some 1,730 children and young people who were in care for one month or longer exited care. Around 70 per cent of these children and young people were aged under 15 years and the majority were reunited with their family. The remainder, or more than 550 young people, were aged 15 years and over and some of these young people return to the family home, while others exited care into independent living. Approximately 400 young people have their custody or guardianship order expire each year.

This chapter is focused on the group of young people whose custody and guardianship order has expired and who exit into independent living. This group is often referred to as the 'leaving care population'. This consideration responds to the Inquiry's Term of Reference relating to the role and functioning of the out-of-home care system including transitions from care.

The chapter outlines the relevant legislative and policy framework relating to leaving care; the range and nature of assistance available to those leaving care and post-care; the available statistics and research on the characteristics and experiences of young people leaving care; and the key issues identified as part of the Inquiry's submission and consultation process. The concluding section sets out a number of key recommendations.

11.2 Current legislative, policy and service framework

11.2.1 Legal framework

Statutory child protection provisions in the *Children, Youth and Families Act 2005* are restricted to children and young people under the age of 17 years or, if the young person is subject of a protection order, continue until the young person is 18 years. As a consequence, the out-of-home care system outlined in Chapter 10, including the provision of residential care placements and home-based caregiver re-imbursements, generally ceases to apply once a young person turns 18 years. From a legal perspective, leaving care has historically been defined as the cessation of legal responsibility by the State for young people living in out-of-home care.

A major finding of the 1989 report of the *National Inquiry into Homeless Children* (Burdekin report) by the Human Rights and Equal Opportunity Commission was that a large number of homeless young people came from a State care background. This was the beginning of a significant debate on the importance of youth transition and the issue of State responsibility for transition and post-care support. The *Children, Youth and Families Act 2005* included, for the first time, legislative responsibility for the provision of transition and post-care services for young people leaving out-of-home care. Section 16 (1) of the Act outlines, as part of the responsibilities of the Secretary of the Department of Human Services (DHS), a responsibility to assist the transition of young people to independent living as follows:

- ... (g) to provide or arrange for the provision of services to assist in supporting a person under the age of 21 years to gain the capacity to make the transition to independent living where the person –
 - (i.) has been in the custody or under the guardianship of the Secretary; and
 - (ii.) on leaving the custody or guardianship of the Secretary is of an age to, or intends to, live independently.

Section 16 goes on to state:

- ... (4) The kinds of services that may be provided to support a person to make the transition to independent living include –
 - a) the provision of information about available resources and services;
 - b) depending on the Secretary's assessment of need –
 - (i.) financial assistance;
 - (ii.) assistance in obtaining accommodation or setting up a residence;
 - (iii.) assistance with education and training;
 - (iv.) assistance with finding employment;
 - (v.) assistance in obtaining legal advice;
 - (vi.) assistance in gaining access to health and community services;
 - c) counselling and support.

11.2.2 Policy and processes framework

The DHS *Child Protection Practice Manual*, and a number of recent policy papers, set out the broad principles and processes that have been developed for young people leaving care and making the transition to independent living.

The following presents a summary of the principles, standards and procedures set out in DHS' manual (DHS 2011k, advice no. 1418):

- To ensure young people leaving out-of-home care have optimal success preparation needs to be considered as part of a continuous process of personal development, not as an event that starts only as a young person nears the end of the time in care. It is important that young people leaving care have the necessary support and skills to maximise their opportunities and feel ready and prepared to leave care (p. 1);
- Each person who leaves an out-of-home care placement should do so in a planned and supported manner to enable a successful and sustainable transition. Young people should have:
 - ongoing opportunities to develop independent living skills;
 - involvement in decision making;
 - have a detailed post-placement support (or after care) plan; and
 - should leave care with relevant documentation, possessions and life records.
- Members of the young person's care team share responsibility for the preparation of young people for independent living (p. 2).
- Preparation for independence: preparation and planning for leaving care should ideally commence two years prior to a young person's transition from care. Young people need time and experience to learn the skills necessary for successful independent living. Young people learn through observation, role modelling, practice and support during times of success and failure (p. 2).
- Conversations should commence with the young person about what they see themselves doing as an adult. These conversations should occur incrementally to allow the young person to deal with these life decisions in a supported manner. Preparation for leaving care must be included as a component of best interests planning and include the following considerations:
 - reunification with family;
 - an appropriate alternative long-term care environment, links into disability services if required;
 - remaining in the current care environment with a change of goals and timeframes for the placement reflected in a revised placement agreement;
 - an independent or semi-supported living situation, if the young person has sufficient living skills to safely sustain such an arrangement;
 - a less intensive care environment in the case of young people placed in intensive support arrangements, particularly non-family based care; and
 - whether a review of the existing child protection order is required (pp. 2-3).
- Post-placement support. As part of the best interests planning process the care team should ensure the best interests plan clearly outlines who is responsible for the tasks that are required when a child or young person transitions from placement. These tasks include:
 - to ensure access to the necessary supports to maintain the young people safely at home, where the young person returns to their parents care, or in their transition to an independent living situation (including links to community support agencies);
 - to clarify any ongoing living, contact or respite arrangements between the young person and their carer;
 - to review the best interests plan for the young person, using the relevant assessments and decision making tools to determine whether ongoing intervention is required to meet the young person's protection and care needs; and
 - in relation to the carers discuss the outcomes of the placement, including:
 - identified strengths demonstrated in managing the placement; and
 - learning and support needs for future placements (p. 3).

11.2.3 Leaving care initiatives and services

Against this legislative and policy and procedures framework, DHS in recent years has developed and implemented a range of specific leaving care services and housing initiatives specifically focused on the leaving care population. The specific leaving care services developed and funded by DHS include:

- A leaving care mentoring program to provide young people transitioning from State care aged 15 to 18 years with the opportunity to interact with adults in community settings and promote personal relationships beyond out-of-home care;
- Post-care support, referral and information services to support young people who require assistance in transitioning to independence or subsequent to leaving State care; and
- Leaving care brokerage funding to provide a flexible support fund for care leavers, both those transitioning from State care and those young people up to 21 years who need support subsequent to their leaving State care.

These services are accessed through a network of more than 20 community service organisations (CSOs) funded by DHS to provide all or a selected range of these services. In addition, funding is provided for the Leaving Care Helpline.

The leaving care brokerage funding, which accounts for the major proportion of funding, provides financial help to assist with specific expenses such as accommodation, education, training and employment, access to health and community services and life skill education for young people up to 18 years who are transitioning from care, as well as young people who have transitioned from care but have subsequently presented with specific needs.

As part of the 2011-12 State Budget the Government announced funding of \$16.9 million over four years to support young care leavers up to 21 years of age improve their educational and employment outcomes. The funding included provision for a new Leaving Care Employment and Education Access Program, additional brokerage and mentoring, a new statewide support system specifically for young Aboriginal people leaving care, and expanded post-care support and information services, particularly in rural regions.

The housing initiatives by DHS' Office of Housing and Community Building span alternative and semi-independent accommodation settings for young people prior to leaving care and the availability of property resources dedicated to young people leaving care. These alternative out-of-home care accommodation settings include the 'foyer' model of youth housing consisting of studio/bed-sits or one-bedroom flats where a range of young people including those leaving care can develop and trial independent living skills in a supported environment.

More broadly, the focus on alternative and stable accommodation arrangements is linked to the Council of Australian Governments (COAG) auspiced *National Framework for Protecting Australia's Children 2009-2020*, which outlined strategies to expand housing and homelessness services for families and children at risk and improve support for young people leaving care. Actions identified under the strategies include additional specialist support to children who are homeless including closer links between homelessness and child protection services and implementing a policy of 'no exits into homelessness' from statutory services.

The housing and homelessness actions in respect of young people in out-of-home care in the *National Framework for Protecting Australia's Children 2009-2010* are linked to the *National Partnership Agreement on Homelessness*. In Victoria, DHS' Office of Housing and Community Building has developed the Leaving Care Housing and Support Initiative for young people whose custody and guardianship orders are due to expire and where the young person has been assessed as at risk of homelessness. The initiative is focused on funding proactive and intensive support for young people, with an emphasis on early intervention housing support.

In addition, DHS has, since 2003, provided reimbursements to the home-based carers of young people who turn 18 and are enrolled in secondary education. In 2010, in recognition of the need to support young people in home-based care to complete their secondary education, DHS extended the policy to include the year beyond which young people turn 18, when they are attending school. Currently this policy applies to over 50 young people.

Finally, in terms of financial assistance available to those leaving care, the Commonwealth Government, through the Transition to Independent Living Allowance, provides up to \$1,500 to assist eligible young people who are making the transition from informal and formal care to independent living. Eligibility is based on a range of factors including age and assessed as being at risk of or experiencing an unsuccessful exit from care.

11.3 Leaving care population: characteristics and experiences

There is only limited statistical and research information available on the characteristics and experiences of those children and young people leaving care in Victoria and elsewhere in Australia.

11.3.1 Characteristics

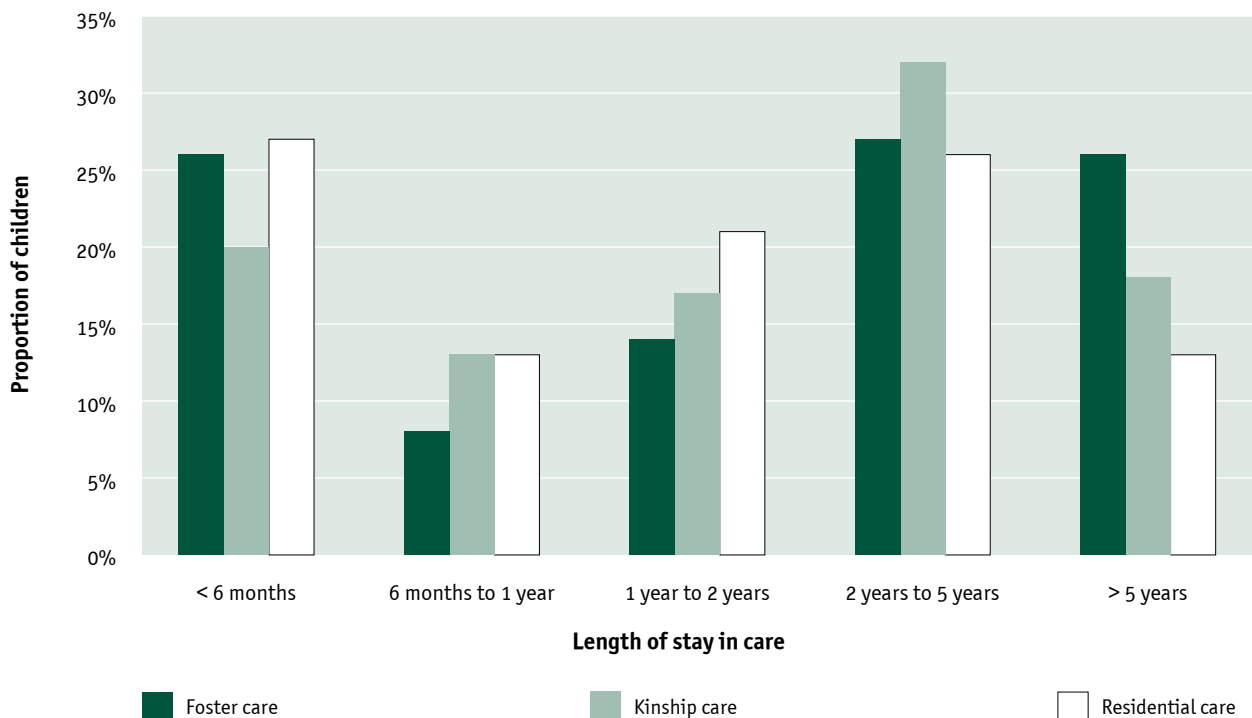
An analysis of the characteristics of the 590 children aged 15 years or over who exited care in 2009-10 after more than one month in non-respite care provides some approximate information. This analysis indicates:

- 46 per cent were male and 56 per cent female;
- 13 per cent of those leaving care were Aboriginal young people;
- Foster care, kinship and residential care each accounted for around 30 per cent of the exited placements;
- Females were more likely to be exiting from foster care and kinship care and males from residential care;
- Nearly 50 per cent had been in care for more than two years, which compares with just under 30 per cent for all children and young people who exited care in 2009-10;

- Children exiting residential care generally had shorter periods in care than those exiting from foster care and kinship care (see Figure 11.1);
- As depicted in Figure 11.2, 65 per cent of the 590 young people who exited care had their first interaction with the out-of-home care system after turning 12 with significant numbers at 14 and 15 years of age. For those whose first interaction was prior to 12 years, the numbers were evenly spread across the individual ages; and
- Children exiting residential care were more likely to have experienced multiple instances of care, with some 52 per cent having had two or more instances compared with 44 per cent for those exiting from foster care and 40 per cent for those leaving kinship care.

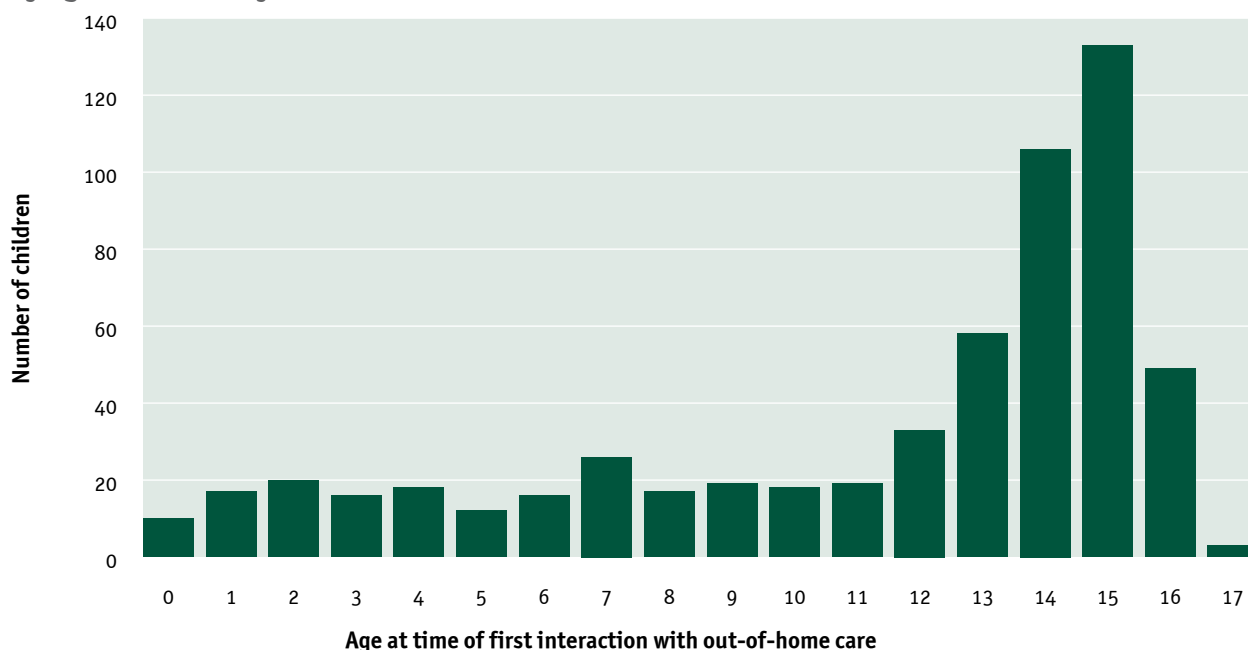
Further, in line with the results presented in Chapter 10 addressing the needs of children in out-of-home care on educational attendance and attainment levels, a significant proportion of those leaving care can be expected to have significantly below average educational attainment levels, with a minority in or having completed Year 12 or the equivalent.

Figure 11.1 Children aged 15 years and over who exited out-of-home care in 2009-10, by length of placement and type of care, Victoria



Source: Inquiry analysis of information provided by DHS

Figure 11.2 Children aged 15 years and over who exited out-of-home care in 2009-10, by age of first entry into care, Victoria



Source: Inquiry analysis of data provided by DHS

11.3.2 Research

Comprehensive and regular data on the experiences of those leaving care in Victoria are not available. Over the past 15 years there have been a small number of research studies conducted in Australia on the experiences of those leaving State care. However, the studies have tended to be small-scale studies of care leavers that are mostly descriptive with limited statistical analysis of the factors associated with successful and unsuccessful leaving care experiences and the effectiveness of specific programs.

In 2007 Osborn and Bromfield summarised the available Australian research on the outcomes for young people leaving care in the following terms:

- Young people leaving care are at great risk of experiencing negative life outcomes;
- Periods of homelessness and committing offences affect close to half of the young people leaving care;
- There are a range of factors that inhibit the transition of young people that need to be acknowledged and addressed prior to the young person transitioning from care to independence. These include: unresolved anger towards family members, workers or the system; unsuitable and unstable placements and multiple changes of carers and workers; lack of long-term goals (such as education, vocation and living arrangements); lack of sufficient income; contact with the juvenile justice system and imprisonment; lack of preparation for leaving care; and lack of later contact with the care system; and

- Young people need to develop more employment and independent living skills and more social and emotional skills before they can be expected (or are able) to live independently (Osborn & Bromfield 2007).

In terms of Victorian studies, in 2005 Raman et al. published the research results of a study undertaken by the Centre for Excellence in Child and Family Welfare in partnership with Monash University on the economic benefits of supporting young people leaving care. The study included a detailed survey of 60 young people aged 18 and 25 years who had been in foster care, kinship care or residential care in Victoria for at least two years as teenagers.

In summary, the study found:

- 60 per cent of participants first entered care at age 12 or more and were fairly evenly split between residential care and foster care, with a small number in kinship care;
- 47 per cent of survey participants were discharged from care before the age of 18 years and only just over 50 per cent had a case plan involving stable accommodation;
- Almost 50 per cent were unemployed, in jail or taking on parenting roles at the time of leaving care;
- 43 per cent indicated they did not receive any help from any family member in the first two years after leaving care;
- Only 5 per cent were in full-time work, with 53 per cent neither working or studying;

- 35 per cent had moved living situations more than five times in the past 12 months and 47 per cent were in some kind of temporary or transitional housing;
- 50 per cent had sought help from a mental health professional in the past six months;
- 35 per cent had accessed drug and alcohol services in the past 12 months; and
- 37 per cent had been charged with an offence in the past 12 months.

In terms of the factors that had a significant positive impact on the leaving care experience, the study found:

- Young people who had a stable housing plan at their exit from care were also three times more likely to be employed at the time of the survey; and
- Young people who received help from anyone of any kind at the leaving care stage, including help to find employment, financial assistance, emotional support or finding accommodation had significantly improved outcomes, for example, employment, sense of wellbeing and resilience and reduced involvement with police and crime.

The 2005 survey also serves to highlight a sub group of the leaving care population that require particular support, namely young parents, particularly expectant mothers. Chapters 7 and 8 discuss this group of vulnerable young people in further detail and the provision of appropriate support and assistance.

A 2006 Australian study by Morgan Disney & Associates and Access Economics focused on documenting the pathways typically experienced by young people leaving care. Based on an examination of the available data, including a random sample of young people who accessed the Transition to Independent Living Allowance and extensive interviews with practitioners in the adult service systems, the researchers developed a number of representative pathways in terms of frequency and depth of usage or interaction with the general health, income support, employment support, housing support, mental health, drug and alcohol and justice systems. The researchers also simulated the lifetime and annual costs to government of this service usage.

The researchers postulated that around 45 per cent of young people who leave care in any one year are likely to be very low or low service users and make a significant contribution to the economy and the community. Conversely around 55 per cent were postulated to be in pathways that incur higher service costs across their life with these costs increasing over time. It was estimated that individuals in the high service use pathway cost governments, on average, approximately \$2.2 million per person over the lifespan from 16 up to 60 years, with an overall estimated average cost per annum of \$50,000 in 2006 dollars.

The emphasis on housing as a necessary pre-condition for successful transition identified in Raman et al. (2005) was the focus of a recent study undertaken for the Australia Housing and Urban Research Institute by academics from a number of the institute's research centres. The study included a survey of young people aged 18 to 25 years who had been in State out-of-home care in Victoria and Western Australia in inner city, suburban and regional locations. In keeping with the Raman et al. (2005) and Morgan Disney & Associates et al. (2006) research, the study identified two distinct pathways from care – those who experienced a smooth pathway from care and those who experienced a volatile transition. While the study found that housing was a critical element in responding to care leavers' needs, the presence of reliable, sustainable social relationships was found to be equally important.

The study also explored the links between the care experience and transition from care. In particular, the study found:

... those who had a smooth transition from care:

- Had few placements in care;
- Generally felt safe and secure in care;
- Felt involved in the planning process;
- Left care at a later stage;
- Felt they were better prepared for leaving care; and
- Had a successful first placement, which facilitated a smoother transition from care (Johnson et al. 2010).

In contrast, those whose transition from care was volatile were likely to have:

- Had a high number of placements in care;
- Experienced physical and/or sexual abuse prior to, or while they were in care;
- Rarely had an exit plan;
- Left care in crisis at a younger age; and
- Been discharged into inappropriate accommodation, such as refuges or boarding houses.

11.3.3 Usage of leaving care services

DHS allocates nearly \$4 million annually for leaving care services covering post-care support; information and referral; mentoring; and financial assistance.

There is currently limited information available on the usage of these services by the leaving care and post-care population. No formal evaluation of the impact of the leaving care services and programs introduced in recent years has been conducted. However, anecdotal information suggests the support, information and referral and financial assistance components are accessed more than mentoring services. DHS advised the Inquiry that an audit in September 2010 of 95 young people who were on custody or guardianship orders and aged 17 and 18 years found that 85 per cent of the client files reviewed had documented evidence of transition planning and 15 per cent lacked evidence.

11.4 Perspectives on Victoria's leaving care arrangements

The available research findings all indicate that many young people leaving care face significant barriers to accessing educational, employment and other transitional and developmental opportunities. The submissions and views presented to the Inquiry on the leaving care issue focused on the vulnerability of young people leaving care at 18 years and the requirement for a more graduated system with support and access to a comprehensive range of services and assistance.

Mendes identified the main reasons for vulnerability of many young people leaving as:

First, many have experienced or are still recovering from considerable abuse or neglect prior to entering care. Secondly, many young people have experienced inadequacies in state care. That is, the state as corporate parent fails to provide the ongoing financial, social and emotional support and nurturing offered by most families of origin. Thirdly, many care leavers can call on little, if any, direct family support or other community networks to ease their involvement into independent living.

In addition to these major disadvantages, many young people currently experience an abrupt end at 16-18 years of age to the formal support networks of state care. (Mendes submission, p. 1).

As outlined in Chapter 5, some submissions argued to the Inquiry that 18 years is not a realistic age for a child or young person to be living independently by today's standards. For example, The Salvation Army submitted:

It is unreasonable to expect all young people who have experienced significant trauma and who have lived in out-of-home care to transition to independent living by the age of 18 years of age. Whilst these young people may have reached the chronological age of 18 years developmentally they may be significantly younger. These young people in particular need access to a secure base and support that is tailored to their needs. Once again, we ask children and young people, who have experienced instability and trauma in childhood, to cope with significantly less support than we expect and provide to our own children (The Salvation Army submission, p. 21).

Anglicare Victoria put this position more starkly:

Anglicare Victoria believes the concept of 'leaving care' is an artificial construction. The physiological, emotional, economic and social realities require delivery of ongoing care and guidance from significant adults well past the age of 18 years. Yet, we have created systems and policies around this chronological age (Anglicare Victoria submission, p. 39).

The CREATE Foundation submission referred to the Australian Bureau of Statistics (ABS) *2006-2007 Family Characteristics and Transition Survey*, which showed that 82 per cent of 18 to 19 year olds were still living with their parents; 47.2 per cent of 20 to 24 year olds were still living with their parents; and the median age for first leaving home for 18 to 34 year olds was 20.9 years for males and 19.8 years for females (CREATE Foundation submission, p. 4).

The final report of the CREATE Foundation on the views and opinions of children and young people about the out-of-home care system commissioned by the Inquiry observed:

Those young people who had begun leaving care planning or were at an age to begin thinking about their transition to adulthood, stated they all struggled with the leaving care process, particularly having to think about how they were going to get to independent adulthood at an age younger than young people in the general population. They suggested that the age for leaving care be raised to at least 21, with options for support until the age of 25. All the young people in the focus groups held a sense of unfairness that 'normal young people' didn't need to leave home until a much later age, and they were forced to consider their adult needs prior to 18 years of age (CREATE Foundation 2011, p. 14).

To address this vulnerability and to achieve better outcomes, Mendes identified three key areas: improving the quality of care; a more gradual and flexible transition from care; and more specialised after-care supports:

The first necessary reform is improving the quality of care as positive in-care experiences involving a secure attachment with a supportive carer are essential in order to overcome damaging pre-care experiences of abuse and neglect. This involves providing stability and continuity, an opportunity if at all possible to maintain positive family links which contribute to a positive sense of identity, and assistance to overcome educational deficits and holistic preparation.

The second component is the transition from care which includes both preparation for leaving care, and the actual moving out from the placement into transitional or half-way supportive arrangements from approximately 16 to 21 years. This transition needs to be less accelerated, and instead become a gradual and flexible process based on levels of maturity and skill development, rather than simply age ...

The third component is ongoing support after care till approximately 25 years of age. This may involve a continuation of existing care and supports/or specialist leaving care services in areas such as accommodation, finance, education and employment, health and social networks (Mendes submission, pp. 2-3).

The transition from care and post-care support issues identified by Mendes were emphasised and elaborated in a number of other submissions. For example, St Luke's Anglicare's submission contained the following recommendations:

- That the current legislation is changed to ensure support to care leavers up to 25 years of age;
- That specific vocational and educational responses for care leavers be developed to ensure all care leavers have access to stable accommodation and housing;
- That targeted housing resources be allocated to ensure all care leavers have access to stable accommodation and housing; and
- That the current funding for care leaver support services be increased to ensure all care leavers up to the age of 25 have access to support (p. 23).

Berry Street went further and identified an explicit set of actions at state and Commonwealth government level including:

- That the Children, Youth and Families Act be amended to require the continuation of all forms of financial and other forms of support directed towards the care, protection and wellbeing of children and young people in out-of-home care (including permanent care) at least until the age of 21 years, and the continuation of financial and other forms of support to age 25 as required;
- That children and young people who are or have been the subject of a care and protection order and/or placed in out-of-home care be the highest priority for access to state government housing assistance and accommodation;
- That the state government initiate negotiations with the Commonwealth to establish a Commonwealth-State funding agreement for a range of measures to support care leavers to access post-compulsory education, labour market and employment assistance and housing including:
 - specialised employment assistance and labour market participation care management;
 - fee waivers under the Higher Education Contribution Scheme; and
 - youth allowance at the independent rate for care leavers living in CSO managed residential or lead tenant services.
- That the State Government introduce a fee waiver for all TAFE fees and charges for children and young people that are, or have been, in the care and protection system (Berry Street submission, p. 35).

While noting that the quality of leaving care support in Victoria has been significantly strengthened in recent years, the CREATE Foundation submission observed that the greatest weaknesses in the supports offered to young people leaving care relate to:

- The period of legislated support provision in Victoria for young people transitioning from care to independence is inadequate;
- A lack of compliance with the legislated requirement that all young people leaving care have a leaving plan or transition plan;
- The delivery approach to support services does not provide seamless provision; and
- The awareness and availability of support services and referrals is inconsistent and insufficient (p. 3).

Other significant issues relating to leaving care raised by submissions were the importance of engaging young people in developing relevant care plans and the potential role of mentors. The Salvation Army commented:

Young people are often not invited to attend care team meetings therefore do not have any input into their future. Furthermore, even when they are invited, young people are not always supported to fully participate in their care team meetings which could be a contributing factor to attendance. Work needs to be done with young people to recognise the importance of participating in goal setting and having a voice in their future (The Salvation Army submission, p. 22).

Mentoring forms a part of DHS' funded post-care service provisions. However, the Victorian Youth Mentoring Alliance contended in their submission that young people are often not referred to youth mentoring until they are just about to leave the care system and recommended:

That child protection workers consistently refer young people to youth mentoring programs when they are 16 years old to ensure they have the opportunity to effectively engage with a mentor prior to leaving care (Victorian Youth Mentoring Alliance submission, p. 3).

11.5 Conclusion

While recent and comprehensive data are not available, it is most likely that a significant proportion of young people who leave care in Victoria following the expiry of a guardianship or custody order encounter major issues in the transition to independent living and have long-term negative life outcomes. This is likely to be particularly so for young people in residential care.

A wide range of factors impact on the likelihood of successful transitions of young people leaving care, with many of them similar to the youth cohort generally, such as level of education and availability of personal supports. However, many of the factors are unique for young people in care, namely the expiry of the specific accommodation and specialist supports for young people in care and the automatic requirement to transition to independent living when this is not the norm for the majority of their age cohort.

The Inquiry acknowledges, as indeed did a number of the submissions, that there has been a significant albeit overdue improvement in the Victorian legislative and service provisions for young people leaving care in recent years. In the critical area of post-care employment and education, the Inquiry is also aware the objectives and delivery arrangements for the Victorian Government's Leaving Care Employment and Education Access Program announced in the 2011-12 State Budget are still being developed.

However in this area – as indeed is the case in a number of other areas – there is a significant absence of contemporary data and research on the experiences of those leaving care and their access to, and effectiveness of, the various services and programs that have been put in place to facilitate the transition. Given the government has assumed parental responsibility for these young people, it would seem incumbent that this role extends in to maintaining contact and supporting the young people through this important life 'transition' as a good parent would.

Recommendation 28

The Department of Human Services should collect regular information on the experiences of young people leaving care and their access to leaving care and post-care services and report the initial findings to the Minister in 2012 and thereafter on an annual basis to the proposed Commission for Children and Young People.

The quality of out-of-home care placements in terms of addressing the impact of abuse and neglect on a child or young person and the full range of their development needs, will be critical determinants of the success or otherwise of the transition. In particular, without a significant improvement in educational attendance and attainment for many children and young people in out-of-home care, the leaving care process will inevitably be problematic for many individuals.

However, the Inquiry also considers that there a number of key aspects of current leaving care and post-care arrangements that need to be revised and strengthened. In particular, there is considerable diversity in care leavers in terms of their pre-care and care experiences, their levels of education, social and general living skills and their capacities at the age of 18 years to successfully transition to independent and sustainable lifestyles.

Recommendation 29

The Department of Human Services should have the capacity, including funding capacity, to extend the current home-based care and residential care out-of-home placement and support arrangements, on a voluntary and needs basis, for individual young people beyond 18 years of age.

The Inquiry considers that this extension would be focused on young people whose levels of intellectual, emotional and coping skills are assessed as requiring further development and bolstering if a successful transition is to be achieved.

Recommendation 30

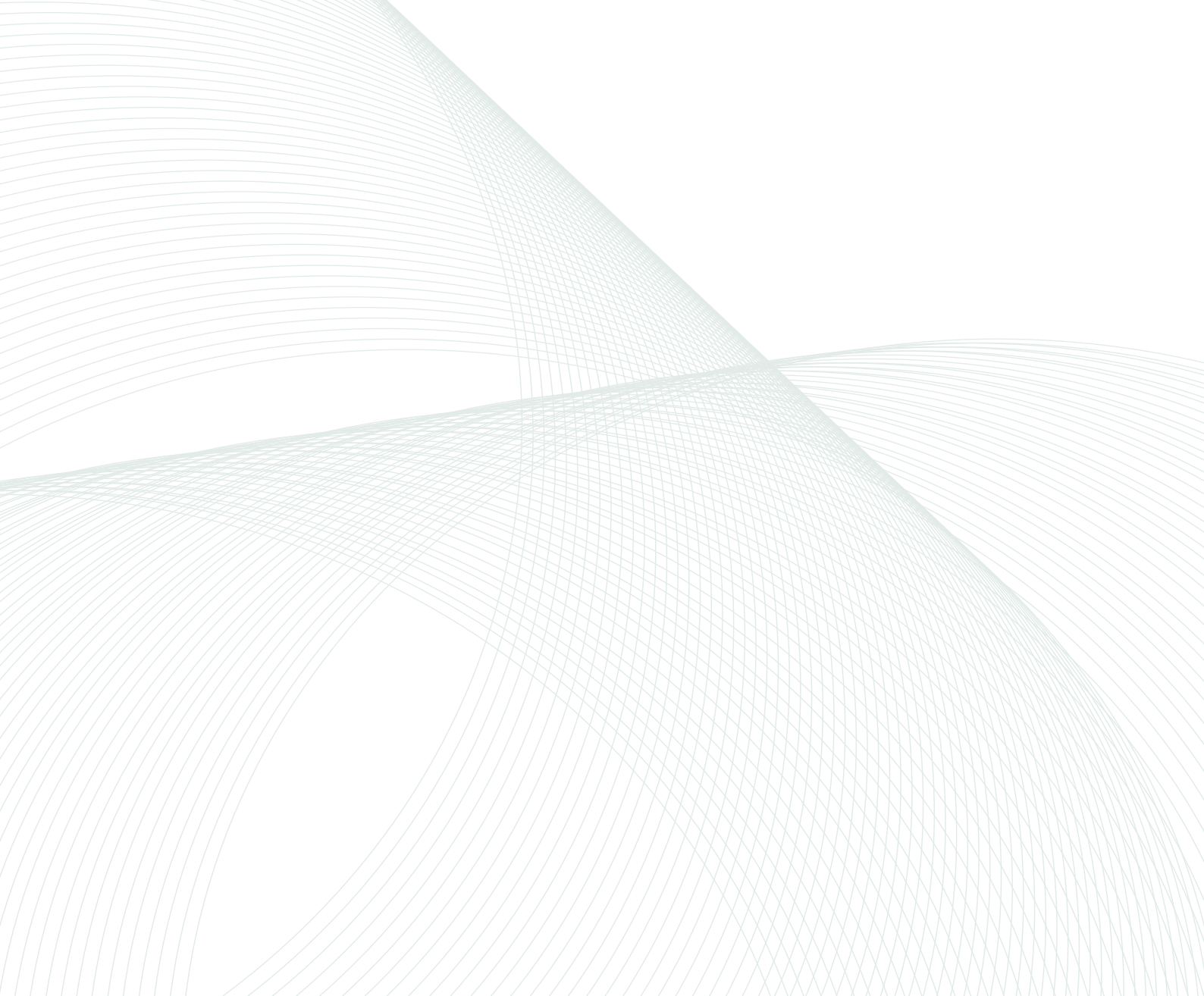
The Department of Human Services should:

- Ensure all leaving care plans identify stable initial accommodation options and that a 'no discharge to temporary and inappropriate accommodation policy' is adopted;
- Review the levels and range of leaving and post-care financial assistance provided to care leavers as part of the development and implementation of the proposed Leaving Care Employment and Education Access Program, including appropriate representations to the Commonwealth Government on their current employment and education assistance programs; and
- Assess the impact of the current leaving care services and programs, as a matter of priority, to determine whether the necessary access to, and integration of, post-care support across the full range of health, housing and other services is being achieved.

As noted, a number of submissions proposed that the Secretary of DHS' statutory responsibilities be amended to provide assistance to care leavers up to 25 years of age. The Inquiry recommends that this should be considered in the medium term following the assessment of the current range of leaving and post-care services and potentially the results of the long-term study assessing the impact of out-of-home care on children announced in the 2011-12 Budget.

Recommendation 31

The Government should consider, in the medium term, the availability of post-care support and periodic follow-up being extended, on a needs basis, until a young person reaches the age of 25 years.



Part 4: Major protective system elements

Chapter 12:

Meeting the needs of Aboriginal children and young people

Chapter 12: Meeting the needs of Aboriginal children and young people

Key points

- The history of Aboriginal communities in Victoria directly impacts on Aboriginal children and families today. Past actions by government and non-government agencies have impacted negatively on Aboriginal families and the result is a continuing experience of trauma in the Aboriginal community.
- The Inquiry has found that outcomes for vulnerable Aboriginal children and their families are generally poor and significant improvement is required in the performance of systems intended to support vulnerable Aboriginal children and families. There is a need to develop specific Aboriginal responses to identify different ways to improve the situation of vulnerable Aboriginal children in Victoria.
- Improving outcomes for Aboriginal children requires active, focused and intense effort across all areas of government activity and within Aboriginal communities. The Inquiry endorses the *Victorian Indigenous Affairs Framework* and associated structures as the primary mechanism to drive action across government on the broad range of risk factors associated with Aboriginal children being at greater risk of abuse and neglect. Building on the Inquiry's earlier recommendation for area-based policy and program design, the Inquiry recommends more detailed monitoring of the *Victorian Indigenous Affairs Framework* should be developed and reported on at the operational level.
- As many vulnerable Aboriginal children and families will continue to receive a range of services from mainstream providers, Aboriginal cultural competence should become a feature of the Department of Human Services' standards for registering community service organisations. Additionally, culturally competent approaches to family and statutory child protection services for Aboriginal children and young people should be expanded.
- The numbers of Aboriginal children involved with Victoria's statutory child protection services and out-of-home care systems continues to rise and is unacceptably high. As part of the recommended Commission for Children and Young People, the Inquiry recommends the creation of a dedicated Aboriginal Children's Commissioner or Deputy Commissioner, to bring an increased focus to improving outcomes for vulnerable Aboriginal children in Victoria across all service systems.
- The adoption of a comprehensive 10 year plan for delegating the care and control of Aboriginal children removed from their families to Aboriginal communities is also recommended. Such a plan will enhance self-determination and provide a practical means for strengthening cultural links for vulnerable Aboriginal children.

12.1 Introduction

As in other jurisdictions Aboriginal children are over-represented in all aspects of Victorian statutory child protection services and have been since data collection commenced in 1990. The ability of statutory child protection services to address entrenched Aboriginal disadvantage is limited. Changing this situation and improving outcomes for Aboriginal children requires active, focused and intense effort across all areas of government activity and within Aboriginal communities.

This chapter considers how vulnerable Aboriginal children and families are faring in Victoria. *The state of Victoria's children 2009: Aboriginal children and young people in Victoria* report (DEECD 2010) shows that, in general, Victorian Aboriginal and non-Aboriginal children, young people, parents/guardians and their families share many of the same strengths and face similar challenges.

The evidence in the report shows many Victorian Aboriginal children have a good start in life, with the majority of Aboriginal women having antenatal check-ups and breastfeeding their babies, many main carers engaging in informal learning activities such as regular reading to the child and a high proportion of immunisation. The vast majority of parents and guardians feel safe at home during the day and report being able to get support in a crisis and have someone to turn to for advice. Many Aboriginal children and young people in Victoria are growing up safe and well in their families.

However, many Aboriginal children and young people in Victoria face challenges those in the non-Aboriginal population do not and may never experience. For example, a high proportion have ear, hearing and dental problems, and many experience daily discrimination, including at school, because they are Aboriginal (DEECD 2010, p. 2). The Inquiry was concerned that significant numbers of Aboriginal adults in households with children were victims of threatened physical violence. All these experiences are risk factors for Aboriginal children's health and wellbeing. In particular, many Aboriginal children, young people and families experience cumulative risk factors and this is a challenge for the current service system intended to support these children and families.

In this chapter the Inquiry considers the challenge of meeting the needs of vulnerable Aboriginal children and families. The Inquiry considers why good intentions, legislative changes, numerous reviews and various policies and programs have not significantly changed the outcomes for Aboriginal children and families. The Inquiry considers that due to the multifaceted and complex disadvantage experienced by Aboriginal children and their families, progress to improve outcomes for Aboriginal children is, and is likely to remain, slow. Despite the slow progress the Inquiry considers that it is important to continue to invest in programs and reforms that will build a better future for Victorian Aboriginal children.

The Inquiry has received submissions from, and spoken with, Aboriginal people who have identified the need for a more holistic view of the needs and role of Aboriginal communities, a different approach to service provision and the development of clear accountable plans to create a positive future for Aboriginal children and families. The Inquiry concurs with Aboriginal people who have asserted that outcomes for vulnerable Aboriginal children and families will only improve once practical gains in Aboriginal self-determination about children and families are achieved.

This chapter canvasses the historical context that impacts on Victorian Aboriginal communities, the role of government agencies in the past, and the contemporary impact of the Stolen Generations. It proceeds to examine the prevalence of risk factors for child abuse and neglect and the complex policy landscape surrounding Aboriginal disadvantage. The progress of Victorian Aboriginal children across the range of systems designed to support them is then discussed. The chapter considers in detail a broad range of issues raised in submissions received from Aboriginal organisations and communities and others.

The Inquiry has used the term 'Aboriginal' instead of 'Indigenous' when referring to Victorian Aboriginal children and their families as this is the convention in Victoria. However, in relation to data that is extracted from, or linked to, Commonwealth sources or processes the protocol adopted is to use the Commonwealth term of Indigenous.

12.2 Historical context

The history of Aboriginal communities in Victoria directly impacts on Aboriginal children and families today. It is not the intention of this section to provide a comprehensive review of the history of Aboriginal people in Victoria. This section considers the impact that legislation and government and non-government agencies in Victoria have had on Aboriginal families, and the resulting trauma experienced by the Aboriginal community. This provides background to consideration of the over-representation of Aboriginal children and young people in statutory child protection services and highlights the systemic change required to protect vulnerable Aboriginal children from abuse and neglect.

12.2.1 Traditional communities

Aboriginal Victorians have lived on this land for more than 40,000 years and are one of the oldest living cultures in the world. The traditional culture of Aboriginal communities is complex and a sense of identity and spirituality is defined by the land, the law, economics, politics, education and extended kinship networks (Department of Education and Early Childhood Development (DEECD), 2010, p. 24). Traditionally, Aboriginal communities in Victoria lived in large social groups. These communities identified as language-culture groups, with 36 to 40 in existence across Victoria at the time of European settlement, though they were not necessarily distinct groups. Often inter-group marriage occurred to develop alliances or to maintain relationships. These groups were also sometimes involved in larger coalitions that shared a similar language and culture, as well as spiritual beliefs. For example, in central Victoria the Kulin nation was formed from five groups that occupied adjacent territories (Broome, in DEECD 2010).

12.2.2 Colonisation

The complex culture of Aboriginal people was devastated with the arrival of the first European settlers in 1835. For example, prior to colonisation there were approximately 40 different languages spoken in Victoria. Most of these languages have been lost and the survival of remaining few languages is threatened (Victorian Aboriginal Corporation for Languages 2011). Over time colonisation has driven the decline in the health and wellbeing of Aboriginal Victorians, including children and young people across generations (DEECD 2010, p. 24).

In Victoria, European settlement brought rapid change over a relatively short period of time (DEECD 2010, p. 25). For example, in 1836, the Kulin population, whose nation had surrounded Port Philip and Western Port bays, was estimated to be 30,000 to 70,000. The battles over land and various diseases reduced this population to such a degree that by 1863 only 250 Kulin remained. Other Victorian districts had been depopulated to a similar extent (Pascoe, in Perkins & Langton 2008, p. 119).

The systematic marginalisation of Aboriginal people by the government of Victoria began in the period from 1850 to 1901. This is documented through the individual stories of Aboriginal people in *Wurrbunj Narrap: Lament for Country* by Bruce Pascoe. Pascoe states that a 'sophisticated war' was waged in Victoria against Aboriginal people (Pascoe, in Perkins & Langton 2008, p. 119). This sophisticated war was, in Pascoe's opinion, the use of legislation to create powers for government agencies to directly intervene in and control the lives of Aboriginal people in Victoria.

In 1858 the Victorian Government established a Select Committee to inquire into the living conditions of Aboriginal people in Victoria. The subsequent report accepted that Aboriginal communities had witnessed 'their hunting grounds and means of living taken from them' as an outcome of the British occupation of Aboriginal land. The Select Committee concluded Aboriginal people were themselves responsible for this outcome:

... had they been a strong race, like the New Zealanders, they would have forced the new occupiers of their country to provide for them; but being weak and ignorant, even for savages, they have been treated with almost utter neglect (Select Committee of the Legislative Council 1859, p. iv).

The report recommended that reserves be established in remote areas of the colony, both to 'protect' Aboriginal people from further injustices and to ensure that Aboriginal people be contained in order to restrict their freedom and place greater controls over their lives (Select Committee of the Legislative Council 1859, pp. iii-vi).

Following the 1858 report the Board for the Protection of Aborigines was established in 1860 to administer government reserves and missions. The protectorate system brought Aboriginal people into centralised missions in return for rations (Pascoe, in Perkins & Langton 2008, p. 125). These reserves were run on a system of Christian education and enforced labour. The traditions of Aboriginal society, including ceremonial practices, were often banned.

At this time any Aboriginal person who continued to live on their own land was subject to the authority of government appointed local guardians, such as police, clergymen or European landholders (Museum Victoria 2011) .

From the beginning of colonisation there are documented accounts of Aboriginal leaders such as Billibellary, Simon Wonga, William Barak, Louisa Briggs and Jessie Donally, who sought to negotiate with the government for land, fair treatment and independence (Pascoe, in Perkins & Langton 2008, pp. 117-169).

There are also examples of well-meaning government employees such as William Thomas and John Green working with and on behalf of the Kulin (Pascoe, in Perkins & Langton 2008, p. 162). While these men had good intentions they held views that prevented them from understanding Aboriginal communities. For example, Thomas was considered a good Christian, but even he thought of the people as unenlightened savages (Pascoe, in Perkins & Langton 2008, p. 125) and Green looked on Kulin as childlike and doomed to disappearance (Pascoe, in Perkins & Langton 2008, p. 139).

12.2.3 Role of legislation and government agencies

Legislation and government agencies established to protect Aboriginal people became mechanisms that deliberately separated Aboriginal children from their families from colonisation until the late 1960s (Table 12.1).

At first in the reserves, such as Coranderrk at Healesville, east of Melbourne, separate living quarters were built for children, with an attached schoolroom. Then in 1875 the Board for the Protection of Aborigines proposed that all Aboriginal children be removed from what it termed 'wandering blacks' who had continued to live an autonomous life, outside the control of the reserves. In 1886 the board was given powers to separate Aboriginal children from their families and communities for the purpose of care, custody and education of the children of Aborigines.

In this same year the Board for the Protection of Aborigines amended the Aborigines Act 1886 which removed 'half-castes' from the reserves and intended to 'let the "old full bloods" die out'. The resulting destruction of Aboriginal families has resonated through the generations (Perkins & Langton 2008, p. xxvii).

This policy forcibly removed 'half caste' Aborigines from missions and reserves and forbade them access to mission stations and their families. 'Half-caste' children were removed from their parents on the missions when they were old enough to work and, under the authority of the Board, were sent out to service following a period of training, or for adoption with non-Aboriginal families (McCallum 2007, p. 9). The 1886 Act empowered the Board to transfer Aboriginal children to State care even when they were not orphaned.

The *Aborigines Act 1910* abandoned the distinction in law between 'full-blood' and 'half-caste' in terms of defining Aboriginality. This meant that people categorised as 'half-caste' and Aboriginal people living outside Victorian reserves were no longer ineligible for government assistance. The effect of the Aborigines Act was to extend the power of the board over Aboriginal people's lives. The Board was now empowered to make decisions, not only about the Aboriginal people living on its missions and reserves, but about 'half-caste' Aborigines as well.

The 1915 *Aborigines Act* provided that only people categorised as 'full-blood Aborigines' could live on Victorian mission stations. This legislation placed severe restrictions on contact between people on the mission and 'half-castes'. It also excluded Aboriginal people, deemed to be 'half-castes', from government assistance, leading to severe disadvantage and hardship.

In 1957 the new Aborigines Act replaced the Board for the Protection of Aborigines with the Aborigines Welfare Board. The new board had the function 'to promote the moral, intellectual and physical welfare of Aborigines (full-blood and half-caste) with a view to their assimilation in the general community' (Aborigines Act, 1957, section 6 (1)). From this time Aboriginal children were dealt with under the *Children's Welfare Act 1954*. Any removal of Aboriginal children from their family and community by the government from 1957 was enabled by this mainstream child welfare legislation.

A policy shift occurred in 1966 and it was accepted that Aboriginal children should stay with their families if possible (Victorian Aboriginal Child Care Agency (VACCA) 2006, p. 13). The Aborigines Welfare Board was abolished in 1968 when the Victorian Government established a Ministry of Aboriginal Affairs.

In the early 1970s there was a move by Aboriginal people to establish a national framework for protecting the rights of Aboriginal children, and to fund Aboriginal controlled child and family welfare agencies. VACCA was established in 1976 (Dyer 2003).

Table 12.1 Victorian legislation relating to Aboriginals, 1869–1970

Victorian legislation	Objectives	Government agency responsible
Aboriginal Protection Act 1869	<ul style="list-style-type: none"> Established a system of reserves in remote areas and provided powers to separate Aboriginal children from their families and communities to 'educate' them. 	In 1869 the Board for the Protection of Aborigines became responsible for the administration of the Aborigines Protection Act.
Aborigines Protection Act 1886	<ul style="list-style-type: none"> Amended the Aborigines Act to provide powers to remove 'half castes' from the reserves. 	Board for the Protection of Aborigines
Aborigines Act 1910	<ul style="list-style-type: none"> Abandoned the distinction in the law between 'full-blood' and 'half-caste'. Excluded people categorised as 'half-caste' and Aboriginal people living outside Victorian reserves from eligibility for government assistance. Extended the power of the board to make decisions about all Aboriginal people, those on missions and reserves and 'half-caste' Aborigines living elsewhere. 	Board for the Protection of Aborigines
Aborigines Act 1915	<ul style="list-style-type: none"> Provided that only people categorised as 'full-blood Aborigines' could live on Victorian mission stations. Placed severe restrictions on contact between people on the mission and 'half-castes'. Excluded Aboriginal people, deemed to be 'half-castes', from government assistance. 	Board for the Protection of Aborigines
Aborigines Act 1957	<ul style="list-style-type: none"> Abolished the Board and established the Aborigines Welfare Board. Established function of the board 'to promote the moral, intellectual and physical welfare of aborigines ('full blood and half-caste') with a view to their assimilation in the general community'. The Aborigines Welfare Board did not have specific powers in relation to children. 	Aborigines Welfare Board
Children's Welfare Act 1954	<ul style="list-style-type: none"> From 1957 Aboriginal children came under the provisions of the Children's Welfare Act. 	Children's Welfare Department
Aboriginal Affairs Act 1967	<ul style="list-style-type: none"> The Aborigines Welfare Board was abolished in 1968 and the Ministry of Aboriginal Affairs established. 	Ministry of Aboriginal Affairs
Social Welfare Act 1960	<ul style="list-style-type: none"> There were no Aboriginal specific provisions. 	Social Welfare Branch within the Chief Secretary's Department

Source: Inquiry analysis

12.2.4 The Stolen Generations

The generations of Aboriginal children removed from their family are known by many people as the 'Stolen Generations' (Read 1981). These children were fostered out to non-Aboriginal families or brought up in institutions. Many Aboriginal people have been affected directly and many more indirectly by past policies leading to the Stolen Generations. Between 1835 and 1970 it is estimated that across Australia tens of thousands of Aboriginal and Torres Strait Islanders were removed from families and raised in institutions or with non-Aboriginal families (VACCA 2008, p. 13).

Removal of Aboriginal children from their families began soon after colonisation and concerns about the impact of the high rates of removal led to the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families (Human Rights and Equal Opportunity Commission 1997) (DEECD 2010, p. 26).

The Inquiry report *Bringing them home: National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (Australian Human Rights Commission 1997) found that the policies and practices of removal had multiple and profoundly disabling effects on individuals, families and communities, including across generations. This report highlighted that children removed from families were:

- More likely to come to the attention of the police as they grew into adolescence;
- More likely to suffer low self-esteem, depression and mental illness;
- More vulnerable to physical, emotional and sexual abuse;
- Almost always taught to reject their Aboriginality and Aboriginal culture;
- Unable to retain links with their land;
- Unable to take a role in the cultural and spiritual life of their former communities; and
- Unlikely to be able to establish their right to native title (DEECD 2010, p. 26).

On 17 September 1997 in recognition of this history of the Stolen Generations, Premier Kennett issued an apology in the Legislative Assembly to the Aboriginal people for the past policies leading to the removal of Aboriginal children from their families and communities. The apology began with the following comments:

That this house apologises to the Aboriginal people on behalf of all Victorians for the past policies under which Aboriginal children were removed from their families and expresses deep regret at the hurt and distress this has caused and reaffirms its support for reconciliation between all Australians (Parliament of Victoria, Legislative Assembly 1997, p. 107).

On 13 February 2008, Prime Minister Rudd also officially recognised the history of the Stolen Generations and issued an apology in the Australian Parliament. The apology included the following statement:

We apologise for the laws and policies of successive parliaments and governments that have inflicted profound grief, suffering and loss on these our fellow Australians. We apologise especially for the removal of Aboriginal and Torres Strait Islander children from their families, their communities and their country. For the pain, suffering and hurt of these stolen generations, their descendants and for their families left behind, we say sorry (Parliament of ACT, House of Representatives 2008, p. 167).

The history of Victorian Aboriginal people is directly relevant to any discussion about protecting vulnerable Aboriginal children and young people as most Victorian Aboriginal people alive today have directly experienced, or have had parents or extended family members who directly experienced, this policy (see section 12.3.1 for contemporary impact).

12.2.5 From 1970s to the present

From the 1970s onwards, the role of the Victorian Government in the lives of vulnerable Aboriginal children and families has continued to be prescribed and enacted through legislation related to the care and protection of children. Table 12.2 summarises this legislation and highlights sections related specifically to Aboriginal children and families.

Table 12.2 Victorian legislation relating to Aboriginal children and families, 1970-2005

Victorian legislation	Legislation related to Aboriginal children and families	Government agency responsible
<i>Social Welfare Act 1970</i>	Aboriginal children were subject to this Act, however, there were no specific provisions.	Department of Community Welfare Services
<i>Community Welfare Services (Amendment) Act 1978</i>	Aboriginal children were subject to this Act, however, there were no specific provisions.	Community Services Victoria
<i>Children and Young Persons Act 1989</i>	This Act introduced principles of case planning for Aboriginal children that required decision making involve relevant members of the Aboriginal community to which the child belongs.	Community Services Victoria and later the Department of Human Services
<i>Children Youth and Families Act 2005</i>	<p>The Act includes provisions that specifically relate to Aboriginal children:</p> <ul style="list-style-type: none"> • the Aboriginal Child Placement Principle (ACPP) promotes a hierarchy of placement options to ensure that Aboriginal children and young people are maintained within their own biological family, extended family, local Aboriginal community, wider Aboriginal community and maintain their connections to their Aboriginal culture (sections 13 and 14); • a provision for the delegation of the Secretary's functions to the Principal officer of an Aboriginal agency (section 18); and • a provision that the Secretary must prepare and monitor the implementation of a cultural plan for each Aboriginal child placed in out-of-home care under a guardianship to the Secretary order (section 176). 	Department of Human Services

Source: Inquiry analysis

Over many years the legislation has gradually come to include provisions specifically related to Aboriginal children and families.

In 1989 the *Children and Young Persons Act 1989* introduced principles of case planning for Aboriginal children that required decision making to involve relevant members of the Aboriginal community to which the child belongs.

In 2002 the Victorian Government began the process of reviewing the state's statutory child protection service. The review was conducted in three stages comprising an initial report, community consultation and publication of a reform agenda. As part of this process specific consultations were held with Aboriginal communities and organisations.

The first review report was called *Protecting Children: The Child Protection Outcomes Project*. This report identified several potential areas for reform and commented that the reforms areas were likely to be relevant and appropriate for Aboriginal children. However, the report concluded:

That the issues are so important and challenging that it is not possible to adequately address them in this report. They require further examination, led by consultation with Indigenous communities and organisations (The Allen Consulting Group 2003, p. 94).

The second stage of the review was a consultation process. The findings from this consultation process were published in the *Report of the panel to oversee the consultation on Protecting Children: The Child Protection Outcomes Project* (Frieberg et al. 2004). In relation to Aboriginal children and families the report commented:

A key to the successful reform of children's and family services for Aboriginal communities will be ensuring they are developed in an holistic manner. It will not be sufficient to add an Indigenous element to, for example, the assessment and investigation procedure or to make modifications to the out-of-home care processes for Aboriginal children without considering whether the system as a whole is inclusive of Indigenous cultures and values. This will necessitate a greater recognition than is currently the case that the Indigenous communities should be able to exercise a significant measure of control over the provision of services delivered to their communities (Freiberg et al. 2004, p. 43).

In September 2004, the Department of Human Services (DHS) released the third stage of the review process, a report titled *Protecting children: Ten priorities for children's wellbeing and safety in Victoria: Technical options paper*. The report outlined the reforms proposed for Victoria's child protection service, the *Children and Young Persons Act 1989*, the *Community Services Act 1970*, and the Children's Court in 10 key areas.

In relation to Aboriginal children, the technical options paper concluded that Aboriginal services require a holistic approach that includes the community in problem solving and culturally relevant policies and programs.

It was recommended that culturally relevant policies and programs should be legislated to empower Aboriginal communities to take part in decision making and interventions impacting on children and families. The specific options proposed included:

- Incorporating the Aboriginal Child Placement Principle (ACPP) in legislation;
- Inserting a provision in legislation that requires the Minister to assist Aboriginal communities to provide effective prevention and intervention strategies;
- Legislating for the capacity to assign guardianship or custody of an Aboriginal child to a designated person in an Aboriginal organisation or agency; and
- Developing strategies to strengthen the participation of Aboriginal families in decision making processes.

In 2005 the new *Children Youth and Families Act 2005* included specific provisions related to Aboriginal placement principles, provision for transfer of guardianship and the need for cultural plans to maintain the connection of removed children to their community.

The care and protection of children has been reviewed extensively in Victoria since the 1970s (Table 12.3 summarises these reviews). No review, including this Inquiry, has included a specific term of reference about Aboriginal children and families despite the history of the removal of Aboriginal children from their families and the over-representation of Aboriginal children in the child welfare system. The table also highlights that few recommendations were made about Aboriginal children and families. Of the approximately 640 recommendations made by these reviews only six specifically referred to Aboriginal children and families.

The legislative changes and the various reviews of the child welfare system over more than 25 years has only infrequently addressed the needs of Aboriginal children and families who were over-represented in child welfare systems. One notable exception was the 1984 Carney Review. This review acknowledged the history of the removal of children, recommended that the Aboriginal placement principle be included in legislation, that Aboriginal self-determination be supported and that the capacity of Aboriginal organisations be enhanced. In 2005 the ACPP was incorporated into Victorian legislation.

Table 12.3 Victorian reviews of child welfare, 1976 to 2010: consideration of Aboriginal children and families

Date of report	Name of review	TOR specific to Aboriginal children and families	Aboriginal specific recommendations
1976	Norgard <i>Committee of Enquiry into Child Care Services</i>	Nil	One recommendation: <ul style="list-style-type: none"> Aboriginal groups to be given a voice when decisions about children are made (20a).
1984	Carney committee <i>Report of the Child Welfare Practice and Legislation Review (The Carney Committee's Report)</i>	Nil	Three recommendations: <ul style="list-style-type: none"> Changes to Children's Court process (132); Aboriginal child placement principle (164); and Involvement of Aboriginal community members in case planning(184).
1988	Law Reform Commission of Victoria <i>Report on Sexual Offences against Children</i>	Nil	Nil
1989	Mr Justice Fogarty and Ms Delys Sargeant <i>Protective Services for Children in Victoria: Interim Report</i>	Nil	Nil
1990	Victorian Family and Children's Services Council – Standing Committee on Child Protection <i>One year later: Review of the redevelopment of CSV's protective services for children in Victoria</i>	N/A	Nil
1993	Mr Justice Fogarty <i>Protective Services for Children in Victoria: Final report</i>	Nil	Nil
1996	Victorian Auditor-General <i>Protecting Victoria's Children: The Role of the Department of Human Services</i>	Nil	Nil
2001	Public Accounts and Estimates Committee <i>Report on the Review of the Auditor-General's Special Report No.43 – Protecting Victoria's Children: The role of the Department of Human Services</i>	Nil	Nil
2000	Jan Carter and reference group <i>Report of the Community Care Review</i>	Nil	Nil
2005	Victorian Auditor-General <i>Our children are our future: Improving outcomes for children and young people in Out-of-Home Care</i>	Nil	One recommendation: <ul style="list-style-type: none"> Address gaps in out-of-home care in relation to Aboriginal children re: quality; resourcing, flexible service responses and reporting (13).
2009	Victorian Ombudsman <i>Own motion investigation into the Department of Human Services Child Protection Program</i>	N/A	Nil
2010	Child Protection Proceedings Taskforce <i>Report of the child protection proceedings taskforce</i>	Nil	Nil
2010	Victorian Ombudsman <i>Own motion investigation into child protection out-of-home care</i>	N/A	Nil
2010	Victorian Law Reform Commission <i>Protection Applications in the Children's Court</i>	Nil	One recommendation: <ul style="list-style-type: none"> Expanded role for Child Safety Commissioner to advocate for Aboriginal children (Option 5.1 (d)).

Source: Inquiry analysis

12.3 Factors that impact on vulnerability in Aboriginal communities

As outlined in Chapter 2, there are no specific causes of child abuse and neglect, although research recognises that there are a number of risk factors. Children within families and environments in which these risk factors exist have a higher probability of experiencing child abuse and neglect. There is a range of risk factors arising from parent, family or caregiver characteristics including family violence, situational stress, alcohol and substance misuse, mental health problems, attitudes towards parenting, intergenerational abuse, and disability.

Further, there are risk factors that arise from a child's particular characteristics such as the age of the child, language and cognitive factors (including child disability). There are also risk factors associated with community and society such as social inclusion and exclusion and social norms and values.

There are multiple and complex historical, social, community, family and individual factors that underpin why many Aboriginal children are at greater risk of abuse and neglect. However, responding to the entrenched social and economic factors that contribute to the over-representation of Aboriginal children in statutory care and protection services is a critical challenge recognised by Australian state, territory and Commonwealth governments (Berlyn et al. 2011, p. 6).

12.3.1 The impact of family disruption and child removal

As demonstrated in *Bringing them home: National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families* (HEROC 1997) the impact of Aboriginal child removal policies on contemporary Aboriginal communities is particularly profound.

Results from the 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) found that 11.5 per cent of Victorian Aboriginal people who responded to the survey and were living in households with children had been removed from their natural family and 47.1 per cent had a relative who had been removed. This was much higher than the national rate of 7.0 per cent of Aboriginal people in the survey who had been removed from their family and 37.6 per cent who had a family member who had been removed (DEECD 2010, p. 26).

In Victoria, for those people who reported they had a relative removed from their natural family, the majority of 15 to 24 year olds had their (great)/grandparents removed (45.0 per cent), followed by aunties/uncles (30.8 per cent) and cousins, nephews/nieces (27.1 per cent).

When asked in the 2008 Victorian Adolescent Health and Wellbeing Survey, one in five Aboriginal young people aged 12 to 17 responded that they identified as belonging to the Stolen Generations (DEECD 2010, p. 28).

There are no Aboriginal people whose lives have not been adversely affected by the past. In Victoria, there are no families who have not lost contact with members of their family or whose family relationships do not still bear the scars of the Stolen Generations or whose families were not decimated by the forced removal to different missions of family members and then the expulsion of lighter skinned members from the missions. These events happened to Aboriginal people who are alive today (VACCA 2006, p. 9).

12.3.2 Risk factors impacting on Aboriginal children and young people

Parent, family or caregiver risk factors

There is a range of heightened risk factors for abuse and neglect for Aboriginal children and young people arising from parent, family or caregiver characteristics. This heightened risk is evidenced by the prevalence and severity of key risk factors, as identified in the NATSISS. These include:

- Family stress (experienced by self, family or friends) is high in Victorian Aboriginal households, with nearly 80 per cent experiencing one or more life stressors. This was almost double that for non-Aboriginal households and higher than for Aboriginal households in Australia (DEECD 2010, p. 132);
- Approximately a quarter (24.1 per cent) of Aboriginal people aged 25 years and over in households with children were a victim of threatened physical violence; 87.5 per cent of those who experienced physical violence knew the perpetrator (DEECD 2010, p. 198);
- The Victorian Indigenous Family Violence Taskforce estimated that 'one in three Indigenous people are the victim, have a relative who is a victim or witness an act of violence on a daily basis in our communities across Victoria' (Victorian Indigenous Family Violence Taskforce 2003, p. 4);

- Mental illness, serious illness and alcohol and drug-related problems were the stressors that were more likely to be experienced by Victorian Aboriginals than by Aboriginal people across Australia (DEECD 2010, p. 132);
- Approximately a quarter (24.8 per cent) of Victorian Aboriginal parents/guardians had used illicit drugs in the previous 12 months. This figure is higher than Aboriginal parents/guardians nationally (19.1 per cent) (DEECD 2010, p. 142);
- Over one-third (36.6 per cent) of Aboriginal parents/guardians had experienced high or very high psychological distress in Victoria in the previous month when surveyed, with 22.5 per cent of these unable to work or carry out normal activities over the previous four weeks due to their feelings and 16.3 per cent having been to see a health professional about feelings (DEECD 2010, p. 150);
- Almost 16 per cent of Aboriginal couple families had both parents unemployed or not in the labour force, triple that of non-Aboriginal couple families (DEECD 2010, p. 96);
- Just over one in five Aboriginal households had run out of food in the week of the NATSISS survey and could not buy more (DEECD 2010, p. 90);
- In approximately 40 per cent of Aboriginal families, no parent had completed Year 12. This figure is more than double the rate for all families in Australia (DEECD 2010, p. 90);
- The proportion of Aboriginal parents/guardians who drink at high-risk levels is 4.3 per cent, the same as for non-Aboriginal parents/guardians. The majority of Victorian Aboriginal parents/guardians aged 15 years and over drink at low-risk levels (59.0 per cent) lower than amongst non-Aboriginal parents/guardians (68.7 per cent). Of Aboriginal parents/guardians, 14.6 per cent drink at medium-risk levels, which was significantly higher than for non-Aboriginal parents/guardians at 5.1 per cent (DEECD 2010, p. 145); and
- In Victoria the teenage pregnancy rate for Aboriginal women is 4.5 times higher than for non-Aboriginal women (DEECD 2010, p. 232).

Risk factors associated with Aboriginal children

The risk factors that arise from the child's particular characteristics are as follows:

- In Victoria children born to Aboriginal mothers are around twice as likely to be born with either very low or low birth-weight, compared with children born to non-Aboriginal mothers. The likelihood of having a low birth-weight baby is 12.5 per cent for Aboriginal women – almost double the rate of non-Aboriginal women (6.5 per cent) (DEECD 2010, p. 164);
- There are high proportions of ear and hearing and dental health problems among Aboriginal children (dental health is the second leading cause of hospitalisation in Aboriginal children) (DEECD 2010, p. 170); and
- Aboriginal children and young people are almost twice as likely as non-Aboriginal children and young people to have a need for assistance with core activities (2.9 per cent compared with 1.6 per cent) which can be used as a proxy measure for profound disability (DEECD 2010, p. 170).

Risk factors associated with community

The risk factors in Aboriginal communities associated with social inclusion, exclusion, social norms and values include:

- High rates of victimisation and being physically harmed or threatened – this includes experiencing discrimination in daily life, including at school;
- 23.6 per cent of Aboriginal parents/guardians do not have a friend outside the household they can confide in – more than double the proportion of non-Aboriginal parents/guardians (DEECD 2010, p. 55); and
- One in five Aboriginal young people aged 15 to 24 years had experienced physical violence in the 12 months prior to the survey, with only one in three reporting their most recent experience to police (DEECD 2010, p. 196).

The risk factors for abuse and neglect are therefore heightened in the Victorian Aboriginal community for each grouping (parental characteristics, child characteristics and community factors).

12.4 Victorian and Commonwealth policy and services initiatives

Even the best support programs cannot overpower poverty in shaping a child's developmental outcomes (VACCA submission, p. 10).

12.4.1 Closing the Gap

Closing the Gap is a commitment made by all Australian Governments in 2007 to improve the lives of Indigenous Australians and provide a better future for Indigenous children. It is a nationally integrated strategy that has been developed through the Council of Australian Governments (COAG). In partnership with the Commonwealth Government and, through COAG, the Victorian Government is working with Indigenous communities to close the gap between Indigenous and non-Indigenous Victorians.

The six COAG *Closing the Gap* goals incorporated in the *National Indigenous Reform Agreement* are to:

- Close the life expectancy gap within a generation;
- Halve the gap in mortality rates for Indigenous children under five within a decade;
- Ensure all Indigenous four year olds in remote communities have access to early childhood education within five years;
- Halve the gap for Indigenous students in reading, writing and numeracy within a decade;
- Halve the gap for Indigenous people aged 20 to 24 in Year 12 attainment or equivalent attainment rates by 2020; and
- Halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade.

COAG agreements

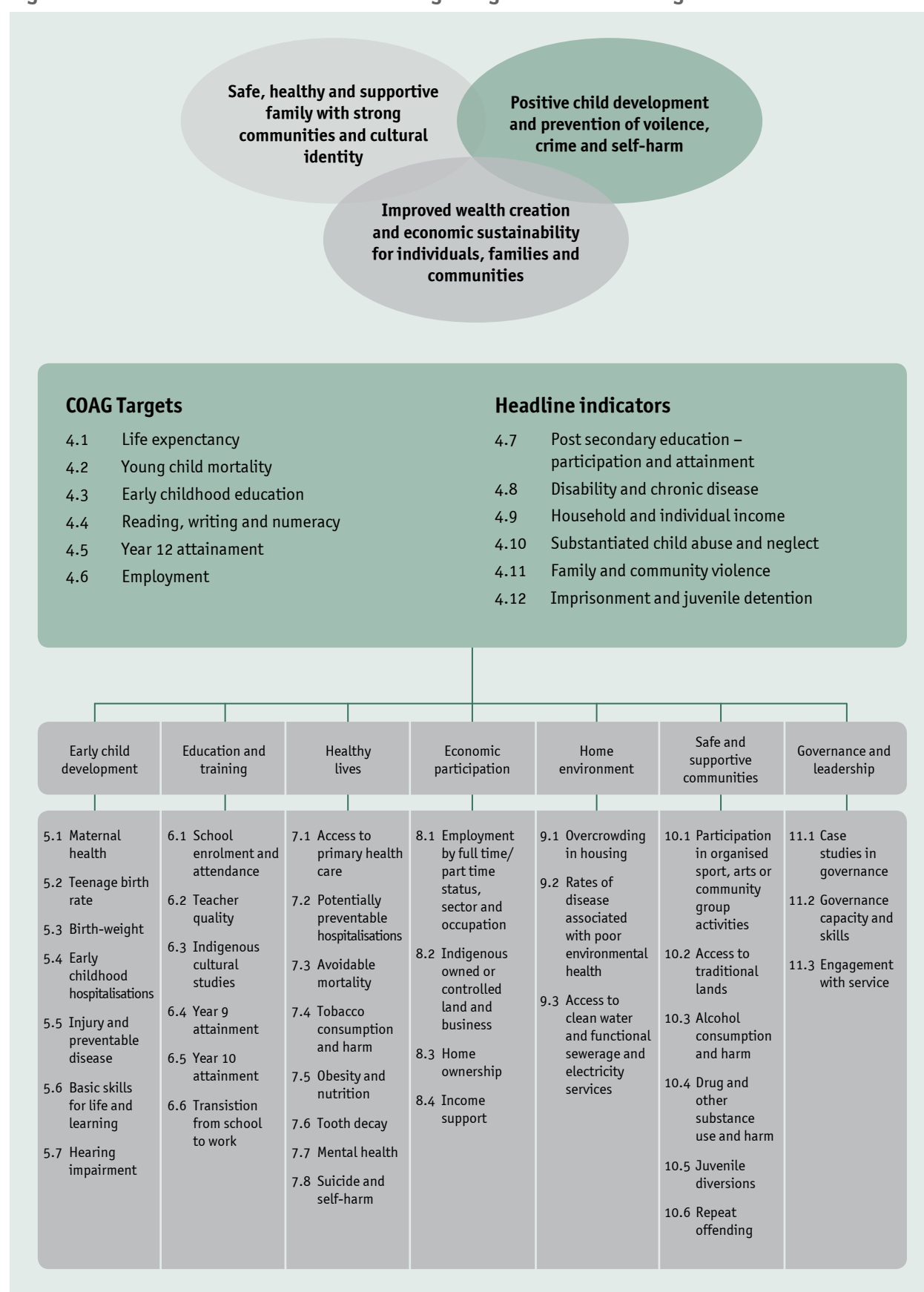
There are several Indigenous-specific COAG national agreements and partnerships signed by the Commonwealth and Victorian governments that are relevant to the achievement of the *Closing the Gap* goals. Implementation responsibility for national agreements and partnerships is with relevant departments and agencies:

- Closing the Gap in Indigenous Health Outcomes National Partnership;
- Indigenous Early Childhood Development National Partnership;
- Indigenous Economic Participation National Partnership;
- National Urban and Regional Service Delivery Strategy for Indigenous Australians; and
- Remote Indigenous Housing National Partnership.

Other major national agreements have been made in the areas of: education and youth transitions; affordable and social housing; workforce development; disability; health and preventative health; homelessness; and early childhood development. These agreements will also contribute to closing the gap between Indigenous and non-Indigenous Victorians

As part of the COAG commitment, governments agreed to a regular public report on progress in the *Overcoming Indigenous Disadvantage: Key Indicators* report. The report is in its fifth edition and provides a summary of current outcomes and examples of programs and policies that appear to be improving those outcomes (Steering Committee for the Review of Government Service Provision (SCRGSP) 2011b, p. 2). Figure 12.1 outlines how the COAG framework is attempting to address key areas of Aboriginal disadvantage by measuring progress and reporting against targets, headline indicators and key areas for improving outcomes.

Figure 12.1 COAG framework for overcoming Indigenous disadvantage



Source: SCRGSP 2011b, p. 11

12.4.2 Victorian Indigenous Affairs Framework

The *Victorian Indigenous Affairs Framework* (VIAF) provides a mechanism to focus on a long term, strategic and progressive effort to improve the health and quality of life of Indigenous Victorians. The framework has six strategic areas for action, principles to guide reform, and outlines partnership, coordination and the management structures that underpin it.

The six strategic areas for action align closely with the goals set by COAG. They are:

- Improve maternal and early childhood health and development;
- Improve education outcomes (formerly 'Improving literacy and numeracy and Improving Year 12 completion or equivalent qualification, develop pathways to employment');
- Improve economic development, settle native title claims and address land access issues;
- Improve health and wellbeing;
- Build Indigenous capacity; and
- Prevent family violence and improve justice outcomes.

These strategic areas for action tackle the most important social and economic determinants of Indigenous disadvantage in Victoria and are monitored and reported publicly through the *Victorian Government Indigenous Affairs Report* (Aboriginal Affairs Taskforce 2011). The report does not cover all action being taken across the Victorian Government in relation to Indigenous affairs, only the areas of strategic priority set out in the VIAF (Victorian Government 2010c). The 2009-10 report outlined the commitment of the new Victorian Government to closing the gap for Aboriginal Victorians. That report also indicated that the Premier has committed to reviewing the VIAF and that this will involve reconsideration of the established targets to improve outcomes for Aboriginal people and ensure they are appropriate.

The report outlines key areas of improvement achieved in Victoria such as:

- Increased three and four year old kindergarten participation;
- Improved attendance at Maternal and Child Health (MCH) clinics at key age milestones;
- Improved literacy and numeracy;
- Reduced rate of self-harm; and
- Increased rates of police response to Indigenous family violence incidents.

While it is encouraging that improvements are being made in these areas the Inquiry notes that this progress is incremental and is building very slowly from a base of significant existing differences between Aboriginal children and non-Aboriginal children in Victoria.

The report also identifies a number of areas where no improvement has been achieved in Victoria. These include:

- Indigenous perinatal mortality rate;
- Percentage of Indigenous babies with birth-weight below 2,500 grams;
- School attendance rates for Indigenous students;
- Successful transition of Indigenous young people aged 18 to 24 years to employment and/or further education; and
- Rates of chronic medical conditions among Indigenous people.

The report highlights three areas where Victoria is lagging behind national averages and improvement is needed. These are:

- Smoking rates;
- School retention rates; and
- Over-representation in the statutory child protection services.

12.4.3 Other plans

There are a number of plans seeking to improve outcomes for the Victorian Aboriginal community in areas of significant disadvantage. Table 12.4 provides a brief summary of the key plans as they relate to the prevention and reduction of abuse and neglect.

Table 12.4 Strategies to address Aboriginal disadvantage

Plan	Lead Agency	Key focus	Outcomes
Dardee Boorai: <i>Victorian charter of safety and wellbeing for Aboriginal children and young people (2008)</i>	DEECD	<p>Defines eight outcome areas and reaffirms six key COAG targets to improve the safety, health, development, learning and wellbeing of Aboriginal children and young people.</p> <p>Describes the roles and responsibilities of families, communities, community controlled organisations and mainstream services.</p> <p>There is no reporting framework for the charter.</p> <p>The charter states the implementation will be outlined and monitored through the <i>Victorian Plan for Aboriginal Children and Young People</i>.</p>	See <i>Victorian Plan for Aboriginal Children and Young People (2010–2020)</i> below.
Balert Booron: <i>the Victorian Plan for Aboriginal Children and Young People (2010–2020)</i>	DEECD	<p>Outlines 44 specific areas of actions to improve the health, safety, development, learning and wellbeing of Aboriginal children and young people in Victoria over 10 years.</p> <p>Thirteen of these specific areas have measurable goals.</p>	The VIAF notes five areas of improvement, five areas of no improvement and three areas lagging behind national averages (refer section 12.4.2).
Wannik: <i>Learning Together – Journey to our Future (the Wannik strategy)</i>	DEECD	Strategy to overcome poor educational outcomes for Koorie students. Its aim is to improve education outcomes for Koorie students by changing the culture and mindset of the government school system, implementing structural reforms and making better use of mainstream efforts and programs.	<p>There are no set targets or milestones.</p> <p>Note the VIAF education outcome areas show no improvement in school attendance, school retention, and transition to employment and further education.</p>
<i>Aboriginal Justice Agreement (AJA)</i> (Two agreements since 2000)	DOJ	The agreement aims to reduce over-representation of Indigenous people in the youth justice and criminal justice system. A partnership between government and Aboriginal organisations has been in place since June 2000 and includes a diverse range of initiatives to reduce initial contact with the system and improve outcomes for Indigenous people at all stages of the youth justice and criminal justice system.	The success of the AJA2 in achieving these objectives is being assessed as part of an independent evaluation. There are no published results.
<i>Aboriginal Human Services Plan</i>	DHS	Since 2000 DHS has worked in partnership with the Aboriginal community to develop a statewide <i>Aboriginal Services Plan</i> . The Plan aims to achieve improvement in the health and wellbeing of Aboriginal people in Victoria in line with that of the general population by understanding causal factors contributing to the disparity in health and wellbeing, maximising the use of primary and preventative services and minimising the need for secondary and tertiary services by Aboriginal people.	The 2008–2010 plan is currently being evaluated and a new plan is being developed for 2011–2013
<i>Strong Culture, Strong Peoples, Strong Families:</i> The Aboriginal family violence strategy 10 year plan (2008)	DPCD	The plan sets out objectives, strategies and actions and is based on a partnership approach between Aboriginal communities, the Regional Action Groups and the Victorian Government to reduce family violence. It provides investment in both improved, integrated responses and in prevention activities. The strategic plan and its implementation plans are reviewed by a partnership forum and periodic independent evaluation.	<p>There are no set targets or milestones.</p> <p>There is no clear reporting framework.</p>

Source: Inquiry analysis

12.4.4 Conclusions on the policy landscape

Improving outcomes for Aboriginal communities is clearly a whole-of-government task, with the responsibility crossing over many areas of state government activity in addition to a significant Commonwealth Government role. The COAG *Closing the Gap* strategy and the VIAF both outline a comprehensive approach to overcoming Aboriginal disadvantage.

In key areas, such as statutory child protection services, progress is slow or hard to achieve. It is considered that without a substantial change in the individual, caregiver and community risk factors the goal of reducing the over-representation of vulnerable Aboriginal children in statutory child protection services will not be achieved. If progress is made in key identified areas of Aboriginal disadvantage through the current Commonwealth and Victorian Government policies this is likely to reduce the risk factors for child abuse and neglect and therefore help to prevent child abuse in Aboriginal communities.

The Victorian issue-specific plans (Table 12.4) are intended to drive change in relation to key areas of Aboriginal disadvantage and fall within the overarching approach established through the *Closing the Gap* strategy and the VIAF. These five plans are at various stages of implementation, achievement and review. Two plans are currently being reviewed, two plans have no set targets or milestones and one plan sets out 44 goals but only measures 13. None of the plans presently have a clear outcomes measurement and reporting framework against which to assess progress. This creates a policy context where the strong focus on the achievement of the goals as outlined in the VIAF is not reflected at the more detailed level of engagement.

For example, the Victorian Auditor-General's Office (VAGO) has reviewed the Wannik strategy and concluded that:

At the beginning of the fourth year DEECD cannot demonstrate whether the Wannik strategy is on track to improve education outcomes for Koorie students (VAGO 2011c, p. vii).

The Victorian Auditor-General has determined that although DEECD has been progressively implementing a range of priority actions, it is unclear whether progress is in line with DEECD's expectations because there are no set targets or milestones. The Victorian Auditor-General further comments that it is not evident that risks to the strategy's implementation are being adequately managed. Unless these issues are addressed, achieving the systemic reforms necessary to improve and sustain education outcomes for Koorie students is not likely (VAGO 2011c, p. vii). It is unsatisfactory that there are no targets or milestones for the Wannik strategy.

In addition the VIAF is based on a statewide monitoring of outcomes and reporting. However, reporting at a state level is not detailed enough to lead to a clear understanding of how the more specific issue based plans are progressing and does not reflect the impact of actions at a location or regional level. Reporting at a local level will provide valuable information about any barriers to implementation and what approaches work best. This knowledge could then be applied more broadly to enhance overall effectiveness.

In order to assist in efforts to prevent child abuse and neglect in Aboriginal communities and reduce the over-representation of Aboriginal children in statutory child protection services it is considered that the VIAF would benefit from the development of a more detailed and drilled down approach in its monitoring framework. It is recommended that the monitoring framework consider in more detail key areas of disadvantage related to vulnerable children (education or family violence, for example) and report local or place-based performance in specific localities with high prevalence rates of risk factors for child abuse and neglect (such as poor Australian Early Development Index (AEDI) scores and high child protection substantiation rates). This would allow for more effective targeting of effort and rigorous analysis of the barriers and obstacles by issue at the local service delivery level.

While the issue specific plans have some shortcomings, the plans related to justice and family violence have resulted from inclusive planning approaches with the Aboriginal community. This typically cascades upwards from community groups through to representation at larger forums and involves the regular demonstration of commitment of the most senior government representatives, Aboriginal leaders and community members through attendance at regular forums. These regular forum meetings (that may extended over more than one day) provide an opportunity to discuss issues in depth, develop relationships and openly report actions and outcomes. Future planning processes in relation to Aboriginal children and families should consider adopting a similar approach.

Finding 7

The Inquiry affirms the *Victorian Indigenous Affairs Framework* and associated structures as the primary mechanism to drive action across government on the broad range of risk factors associated with Aboriginal children being at greater risk of abuse and neglect.

Recommendation 32

More detailed monitoring should be developed for the *Victorian Indigenous Affairs Framework* that provides reports on outcomes at the operational level regarding key areas of disadvantage (such as education attainment or family violence) and in specific localities with high prevalence rates of risk factors for abuse and neglect.

12.5 Service systems

Aboriginal Victorians have access to the same publicly funded service systems as other Victorians. There is a broad range of systems that are applicable to the health and wellbeing of Aboriginal children and families such as health, economic participation, community safety and housing. These service systems are the focus of the COAG and VIAF improvement efforts and the associated monitoring and reporting regimes.

This section focuses on how Aboriginal children, young people and families are faring in the Victorian service systems of early years, education, family services and statutory child protection services. Each of these systems also provide a range of Aboriginal specific programs. A brief description of Aboriginal specific programs in the early years, education, family services and statutory child protection services are included in Appendix 10.

12.5.1 Aboriginal children and families in Victoria

The state of Victoria's children 2009: Aboriginal children and young people in Victoria (DEECD 2010) provides a comprehensive overview of how Aboriginal children and young people fare in the areas of safety, health, development, learning and wellbeing. This section highlights key areas relevant to the Inquiry.

In 2006 the Australian Census showed there were around 33,500 Aboriginal people living in Melbourne and regional Victoria, an increase from 27,800 in 2001. It is estimated that the Aboriginal population in 2010 has further risen to approximately 36,700 people (Victorian Government 2010c, p. 9). The Aboriginal

population in Victoria has a higher growth rate than the population as a whole (Victorian Government 2010c, p. 9).

The 2006 Census of Population and Housing identified that there were 576,700 families in Victoria, with 1.2 per cent of these being Aboriginal at that time. A very high proportion of Aboriginal families are one-parent families: 50.3 per cent compared with 20.6 per cent of all families with children (ABS 2006a). This figure reflects the national data (DEECD 2010, p. 39).

The majority of Aboriginal households in Victoria are one-family households (91.5 per cent), which is slightly higher than Aboriginal households nationally (86.5 per cent). The major difference observed between Victoria and Australia was the proportion of two or more family households, which was considerably lower in Victoria at 6.0 per cent compared with Australia at 10.4 per cent (DEECD 2010, p. 39).

In approximately two-thirds (64.1 per cent) of Aboriginal households in Victoria not all people within that household identified as Aboriginal in contrast to Australia as a whole, where only in 49.6 per cent of households not all people identified as Aboriginal (DEECD 2010, p. 39).

Although Victoria is the second most populated state or territory in Australia, only 0.7 per cent of the population are Aboriginal, the lowest in Australia. Victoria is home to an estimated 14,578 Aboriginal children aged 0 to 17 years, representing 1.2 per cent of all children residing in the state. This proportion is also the lowest in Australia, well below the national average (see Table 12.5).

Although the majority of Victoria's population is concentrated in metropolitan areas, a greater proportion of Victoria's Aboriginal children reside in rural Victoria, at 55.8 per cent compared with metropolitan Victoria at 44.0 per cent (see Table 12.6).

There are marked differences between the age structure of the Aboriginal population and the total population. Children make up almost half (43.5 per cent) of the 33,517 Aboriginal people counted in Victoria, almost double the proportion of children in the total population at 23.6 per cent (DEECD 2010, p. 35).

In summary the Victorian Aboriginal community:

- Is growing rapidly;
- Is widely dispersed across areas of the state with a significant proportion of the community living in regional and rural Victoria;
- Has a very high proportion of single-parent families; and
- Has a very high proportion of children who are over-represented in statutory child protection services.

Table 12.5 Aboriginal children aged 0 to 17 years, states and territories, 2006

State or territory	Children aged 0–17 years (a)		
	Aboriginal	All Children	% of children that are Aboriginal
New South Wales	68,196	1,607,803	4.2%
Victoria	14,578	1,183,258	1.2%
Queensland	65,484	1,004,795	6.5%
South Australia	12,121	350,158	3.5%
Western Australia	30,460	497,808	6.1%
Tasmania	8,087	116,831	6.9%
Northern Territory	26,381	60,854	43.4%
Australian Capital Territory	1,832	77,438	2.4%
Australia	227,215	4,899,568	4.6%

Source: DEECD 2010

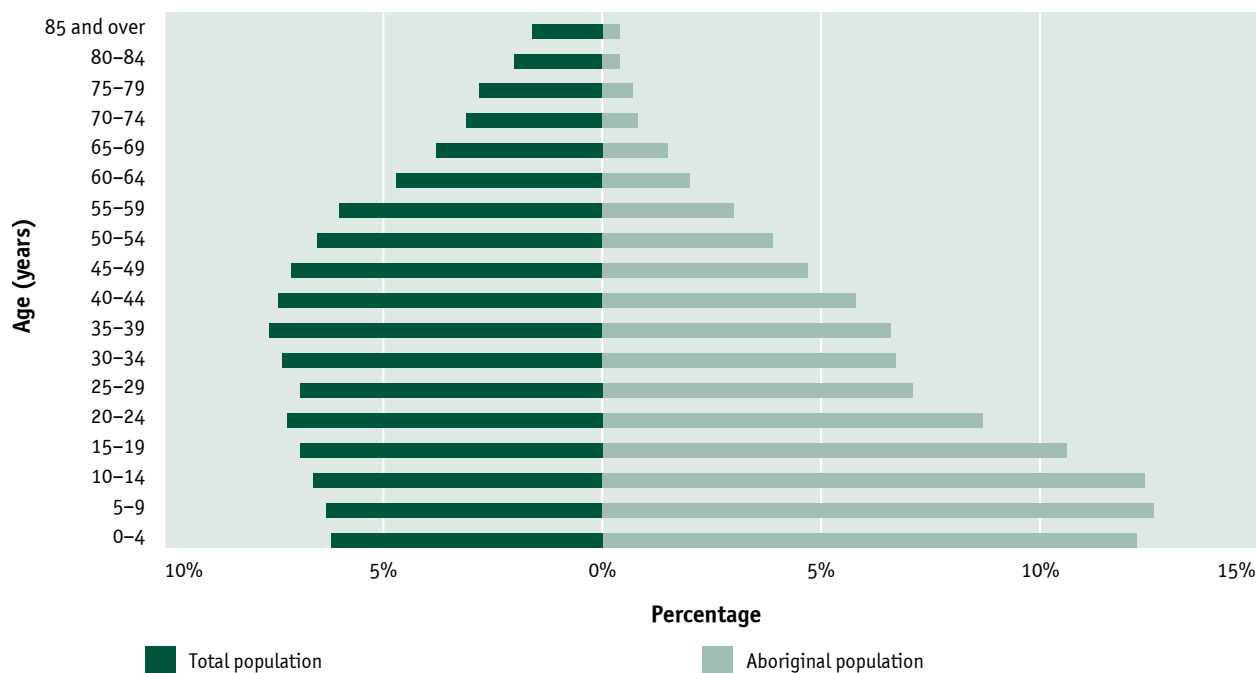
Note: (a) Australian Bureau of Statistics (ABS) 2009a

Table 12.6 Aboriginal children, by age group and region, Victoria, 2006

Region	0 to 4 years	5 to 9 years	10 to 14 years	15 to 17 years	Total 0 to 17 years	% of population aged 0 to 17 years
Eastern Metropolitan	249	319	299	190	1,057	8.0%
Northern Metropolitan	530	500	498	305	1,833	13.9%
Southern Metropolitan	490	553	468	267	1,778	13.5%
Western Metropolitan	324	307	315	201	1,147	8.7%
Metropolitan	1,593	1,679	1,580	963	5,815	44.0%
Barwon-South West	356	371	352	188	1,267	9.6%
Gippsland	377	416	434	217	1,444	10.9%
Grampians	189	220	228	120	757	5.7%
Hume	468	503	503	244	1,718	13.0%
Loddon Mallee	607	612	624	351	2,194	16.6%
Rural	1,997	2,122	2,141	1,120	7,380	55.8%
Victoria (a)	3,598	3,811	3,721	2,086	13,216	100.0%

Source: DEECD 2010

Note: (a) Due to small numbers, 'No usual address' and 'Unincorporated Victoria' categories could not be reported in the table but do contribute to total records (n = 98).

Figure 12.2 Aboriginal population and non-Aboriginal population by age group, Victoria, 2006: percentage distribution

Source: DEECD 2009c, p. 35

12.5.2 System performance data

This section considers the service systems relating to the early years of a child's life, education, family services and statutory child protection services and looks at how Aboriginal children and young people are faring within those systems.

Early years

There is little trend data for the participation of Victorian Aboriginal children in different forms of early years programs. There is also a lack of nationally comparable data regarding participation in early childhood education programs as noted in the Auditor-General's report on the *Administration of the National Partnership on Early Childhood Education* (Australian National Audit Office 2011).

The participation rates of Victorian Aboriginal infants receiving a MCH home consultation visit has increased from 88.2 per cent in 2006-07 to 91.3 per cent in 2007-08 (although it remains lower than for the total population at 98 per cent in 2006-07 and 98.9 per cent 2007-08). The proportion of Victorian Aboriginal children who participate in the 3.5 year old visit remains 20 percentage points behind the whole population (40.3 per cent compared with 60.1 per cent) (DEECD 2010, p. 132).

NATSISS shows that more than half (60.2 per cent) of Aboriginal children aged 0 to 12 years in Victoria had been in some form of child care in the previous week, much higher than all children in this age group (48.9 per cent). Of those who used child care, Aboriginal children were more likely to have been in informal care (with relatives or friends for example) and less likely to have been in formal care only (DEECD 2009c, p. 217).

In 2009-10 in Victoria 0.2 per cent of children attending child care and preschool services were Aboriginal. Aboriginal children between three and five years of age represented 1.2 per cent of all children in this age group in the community (SCRGSP 2011a, table 3A.4).

Around half of 0 to 12 year olds who attended formal care in the week prior to the survey used a long day care centre. The main difference between Aboriginal children and the total population of child care users was in the use of family day care. Aboriginal children were much more likely to be placed in family day care (approximately 20.0 per cent in both Victoria and nationally) compared with all children (7.6 per cent in Victoria, 8.9 per cent nationally) (DEECD 2009c, p. 219).

The Inquiry sought to further understand the attendance at child care by younger vulnerable Aboriginal children, however, this is the extent of data provided by ABS from the NATSISS survey on this subject. DEECD informed the Inquiry that further information had not been sought or additional analysis of NATSISS undertaken in relation to the use of child care.

Aboriginal children in Victoria are assisted by Koori Engagement Support Officers from the Koori Early Childhood Education Program, aimed at increasing participation for Aboriginal children in kindergarten. During the five year period between 2004 and 2009, the number of four year old kindergarten enrolments fluctuated. In 2009, 579 four year olds were enrolled in kindergarten (DEECD 2009c, p. 220).

Table 12.7 outlines the enrolment of three year old Aboriginal children in Early Start Kindergarten. Nearly one third of three year old Aboriginal children were enrolled in 2010.

Table 12.7 Three year old Aboriginal children enrolled in Early Start kindergarten, Victoria, 2008 to 2011

Year	Population projection	Enrolments	Participation rate
2008	838	109	13.0
2009	857	237	27.7
2010	847	249	29.3
2011	876	NYA	NYA

Source: Information provided by DEECD.
Based on ABS 2009a.

Three year old enrolment figures reflect the number of participants in the Aboriginal Early Start program.

Education

In Victoria, Aboriginal students generally have lower rates of literacy and numeracy, school attendance and school retention than their non-Aboriginal peers (VAGO 2011c, p. vii).

Using the AEDI to measure developmental vulnerability, Aboriginal children in Victoria are more than twice as likely as non-Aboriginal children to be vulnerable on one or more health and wellbeing domains at school entry, and nearly three times as likely to be vulnerable on two or more domains (DEECD 2009c, p. 217).

The proportion of Aboriginal children reading with 90 per cent to 100 per cent accuracy at the designated text levels for Prep, Year 1 and Year 2 remains consistently lower than non-Aboriginal children (DEECD 2009c, p. 224) (see Table 12.8).

Table 12.8 reveals that in Prep Aboriginal students are approximately 30 percentage points lower in recommended reading levels than all students. However, by Year 2 this difference has declined by half to 15 percentage points. This average performance difference then appears to remain throughout a child's educational experience. For example, in relation to literacy and numeracy, Aboriginal children and young people in Victoria continue to fare less well than their non-Aboriginal counterparts with differences in Year 9 across reading, writing, spelling, grammar and numeracy at least of the order of 20 percentage points (DEECD 2009c, p. 217).

Aboriginal students are more likely than non-Aboriginal students to be early school leavers. The Year 10 to 12 retention rate for Aboriginal students in government schools has been below 55 per cent for a number of years, compared with approximately 75 per cent for non-Aboriginal students (VAGO 2011c, p. 2).

Table 12.8 Reading proficiency of Prep to Year 2 students enrolled in Victorian government schools, by Aboriginal status, 2000 to 2008

	Year	Text Level	2000 %	2001 %	2002 %	2003 %	2004 %	2005 %	2006 %	2007 %	2008 %	Average 2000–08
Aboriginal students	Prep	5	41.4	44.3	44.4	47.8	49.8	48.0	46.7	49.5	50.3	46.9
	Yr 1	15	48.1	54.2	57.8	57.1	63.7	64.5	61.5	62.6	61.3	59.0
	Yr 2	20	77.9	76.5	75.9	76.3	76.7	82.2	82.7	82.9	81.0	79.1
All students	Prep	5	70.6	74.1	75.9	77.9	79.0	79.7	80.3	80.4	81.3	77.7
	Yr 1	15	79.9	83.1	84.5	85.7	87.0	86.3	86.9	86.7	86.4	85.2
	Yr 2	20	92.9	93.5	94.6	94.5	94.8	94.8	94.9	94.8	94.5	94.4

Source: DEECD 2010, p. 224

Table 12.9 shows that 72.4 per cent of Victorian government schools have at least one Aboriginal student enrolled.

Table 12.9 Victorian government schools with Aboriginal enrolments, 2008 to 2011

Year	Schools with Aboriginal enrolments
2008	71.8%
2009	73.5%
2010	70.9%
2011	72.4%

Source: Information provided by DEECD

Table 12.10 outlines school retention rates for Aboriginal and non-Aboriginal children over a 10 year period. Just over 40 per cent of Aboriginal students aged 12 to 17 years aspire to attend university compared with approximately 70 per cent of non-Aboriginal students (DEECD 2009c, p. 217).

Lower attendance rates among Aboriginal children are consistent across Year 1 to Year 10 in Victorian government schools. Lower rates of attendance were particularly notable in secondary school, for both Aboriginal and non-Aboriginal students in 2007 and 2008 (DEECD 2009c, p. 227).

Aboriginal students report similar levels of connectedness to school and to their peers as their non-Aboriginal counterparts (DEECD 2009c, p. 217). Close to one-third (30.6 per cent) of young Aboriginal people reported that their school recognises Aboriginal culture in its curriculum and nearly 60 per cent felt proud to be an Aboriginal person at school

(DEECD 2009c, p. 231). Approximately 50 per cent of Aboriginal children aged four to 14 years are taught Aboriginal culture at school (DEECD 2009c, p. 217).

Around one in five Aboriginal young people (21.2 per cent) aged 15 to 17 years are not attending an educational institution or participating in employment, compared with 8.8 per cent of Victorian 15 to 17 year olds who are not in either employment or education (DEECD 2010, pp. 243, 246).

Support at school

VACCA supports approximately 40 school aged children in foster care. The children are vulnerable, traumatised and need strong support at school. They all attend school. There have been two short suspensions from school this year [2011]. Both children returned to school immediately. The VACCA education support worker and the extended care team work closely with the school. The support worker can work one-on-one with the child at school if needed, focussing on educational or behavioural difficulties. Teachers feel supported and are included in care team meetings and consultations with therapeutic specialists. Schools are beginning to understand the importance of creating culturally safe environments and including culture into the curriculum. In 2009 all Aboriginal children in VACCA's foster care program achieved literacy and numeracy benchmarks as tested through the National Assessment Program, Literacy and Numeracy (extract from VACCA submission, p. 53).

Table 12.10 Year 10-12 apparent retention rates at all schools (full-time students), Victoria and Australia, 1999 to 2008

	1999 %	2000 %	2001 %	2002 %	2003 %	2004 %	2005 %	2006 %	2007 %	2008 %	Change 1999– 2008
Victoria											
Aboriginal	46.1	37.9	44.0	40.9	44.4	44.7	55.4	47.4	56.7	50.9	+ 4.8% points
Non- Aboriginal	94	95	95	95	95	95	94	92	91	91	- 2.3% points
Australia											
Aboriginal	43.1	43.8	43.6	45.8	45.7	46.0	45.3	46.8	48.5	51.0	+ 7.9% points
Non- Aboriginal	75.0	75.2	76.2	77.8	77.7	78.1	77.5	77.1	76.6	76.5	+ 1.5% points

Source: DEECD 2010, p. 244

Family services

In the 2008-09 financial year, 23,789 families with children accessed family services. Of these, 1,492 (or 6.3 per cent) were Aboriginal families. Given the significant disadvantage in Aboriginal families this low participation rate is concerning because access to appropriate family support programs may prevent the need for engagement with statutory child protection services.

Statutory child protection services

Aboriginal and Torres Strait Islander children are over-represented in all areas of the child protection system in every state and territory in Australia (Australian Institute of Health and Welfare (AIHW) 2011c, p. vii).

The state of Victoria's children 2009: Aboriginal children and young people in Victoria reports that Aboriginal children were 10 times more likely to be the subject of a substantiation at a rate of 48.3 per 1,000 children compared with non-Aboriginal children at a rate of 4.8 per 1,000 children. Nationally, the substantiation rate for Aboriginal children was 37.7 per 1,000 children, 5.8 times the rate of all children (DEECD 2010, p. 206). The Inquiry notes that the VIAF has highlighted this as an area that is lagging behind national averages and improvement is needed. However, due to the lack of

reliable prevalence data about child abuse and neglect, caution needs to be exercised when considering this data. It should not be concluded that Aboriginal children in Victoria are more likely to be abused and neglected than in other jurisdictions. It may indicate that the Victorian system is more responsive to child abuse and neglect in Aboriginal families than in some other jurisdictions.

The Inquiry's own data analysis shows that Aboriginal children are more likely to be the subject of a report of child abuse than non-Aboriginal children. Of the 2009-10 cohort 9.4 per cent of reports of child abuse concerned Aboriginal children. This compares with an estimated 1.2 per cent of children in Victoria who are Aboriginal.

The Inquiry's analysis also shows that there were 1,381 investigations relating to Aboriginal children from reports received in 2009-10. This is equivalent to 9.9 per cent of all investigations. Table 12.11 shows the number of investigations and substantiations based on reports received in 2009-10 by Aboriginal status. At 61.5 per cent, the rate of substantiations as a proportion of investigations is higher for Aboriginal children than for non-Aboriginal children (53.6 per cent).

Table 12.11 Finalised child protection investigations and substantiations arising from 2010-11 reports, by Aboriginal status

	Investigations	Substantiations	Substantiation rate
Aboriginal	1,361	829	63.0%
Non-Aboriginal	11,655	6,811	58.4%

Source: Information provided by DHS

Table 12.12 illustrates the Victorian trends in relation to Aboriginal children in statutory child protection from 2001 to 2010. These trends show a marked increase in relation to reports, a slight decrease in investigations and substantiations and an increase in care and protection orders. While the reasons for these changes are not clearly understood it is likely that the reporting rate is driven by the growing proportion and number of infants in the Aboriginal community. While the changes in investigation and substantiation rates are marked the proportion of substantiations resulting from investigations remains constant (68.5 per cent in 2000-01 and 66.8 per cent in 2009-10). This factor combined with a rise in care and protection orders may indicate that statutory child protection services are appropriately identifying vulnerable Aboriginal children at risk of significant harm.

Out-of-home care

There has been an increase in the rate of children in out-of-home care since 2002 for both Aboriginal and non-Aboriginal children and young people. This increase, combined with the decreasing rate of admissions into out-of-home care, indicates that children and young people are staying in out-of-home care arrangements for longer periods.

In Victoria at 30 June 2009, there were 5,283 children aged 0 to 17 years in out-of-home care, a rate of 4.3 per 1,000 children. Of these, 734 were Aboriginal children, a rate of 48.7 per 1,000. Aboriginal children and young people were 11.3 times more likely to be in out-of-home care on 30 June 2009 than non-Aboriginal children. Across Australia, Aboriginal children were 6.6 times more likely to be in out-of-home care than all children in 2009 (AIHW 2010a).

As outlined in Chapter 10 Victoria's Aboriginal children and young people have markedly higher interactions with the out-of-home care system. The key observations are:

- Over the period 2001-10 the number of Aboriginal children and young people in out-of-home care increased by nearly 80 per cent with the rate per 1,000 Aboriginal children and young people

increasing from 36.5 per cent to 53.7 per cent, an increase of 47 per cent;

- Over the period the median duration of time in continuous out-of-home care increased from an estimated 16 months at the end of June 2001 to just over 2 years at the end of June 2011;
- 95 per cent of Aboriginal children were in home-based arrangements at the end of June 2010 with 51.8 per cent of Aboriginal children in kinship care; Nearly 70 per cent of Aboriginal children who entered care in the 12 months to the end of June 2010 were aged less than 10 years, a significantly higher proportion than for non-Aboriginal population; and
- Aboriginal children and young people who exited care in the 12 months to June 2011 had spent similar periods in care as non-Aboriginal children: 54.4 per cent had been in care for less than 12 months; 21.5 per cent one year to less than two years; and 24.1 per cent more than two years.

In Victoria the majority of both Aboriginal and non-Aboriginal children are placed in home-based care (96.5 per cent and 97.4 per cent respectively). There has been an increasing number of children placed with relatives and kin – higher for Aboriginal children at 52.9 per cent than non-Aboriginal children at 43.5 per cent (DEECD 2010, p. 213).

Caregivers of Aboriginal children were mostly aged over 50 (65 per cent), female and frequently single, and living in poverty with often crowded housing. Aboriginal carers were caring for larger numbers of children (average 2.4) than non-Aboriginal carers (average 1.8). Only half (53 per cent) of carers reported that they had adequate support to ensure that the children keep in contact with family and culture (Humphreys & Kiraly submission (a), pp. 2-3).

On 30 June 2009, 431 Aboriginal children in out-of-home care were living in arrangements that were in accordance with the ACPP. This accounts for 59.5 per cent of Aboriginal children in out-of-home care (DEECD 2010, p. 214).

Table 12.12 Children in child protection reports, investigations, substantiations and care and protection orders per 1,000 Victorian children, by Aboriginal status, 2000-01 and 2010-11

	2000-01		2010-11	
	Aboriginal	Non-Aboriginal	Aboriginal	Non-Aboriginal
Reports	117.6	24.5	178.1	31.1
Investigations	74.1	9.9	76.7	9.0
Substantiations	50.7	6.1	50.4	5.4
Care and protection orders	41.1	3.8	69.2	4.6

Source: SCRGSP 2011c, provided by DHS

This means there are still many Aboriginal children who cannot be placed with Aboriginal families or communities. One of the main reasons for this is the shortage of Aboriginal carers. The underlying factors involved in the ability to recruit Aboriginal carers include the impact of the past removal policies on parenting, social and financial barriers, the unwillingness of some people to be associated with the 'welfare' system and the disproportionately high number of Aboriginal and Torres Strait Islander children compared to adults (Berlyn et al. 2011, p. 5).

The Inquiry understands another factor is the criminal records check requirements for approval for placement in out-of-home care, which means that some Aboriginal adults are ineligible to become carers.

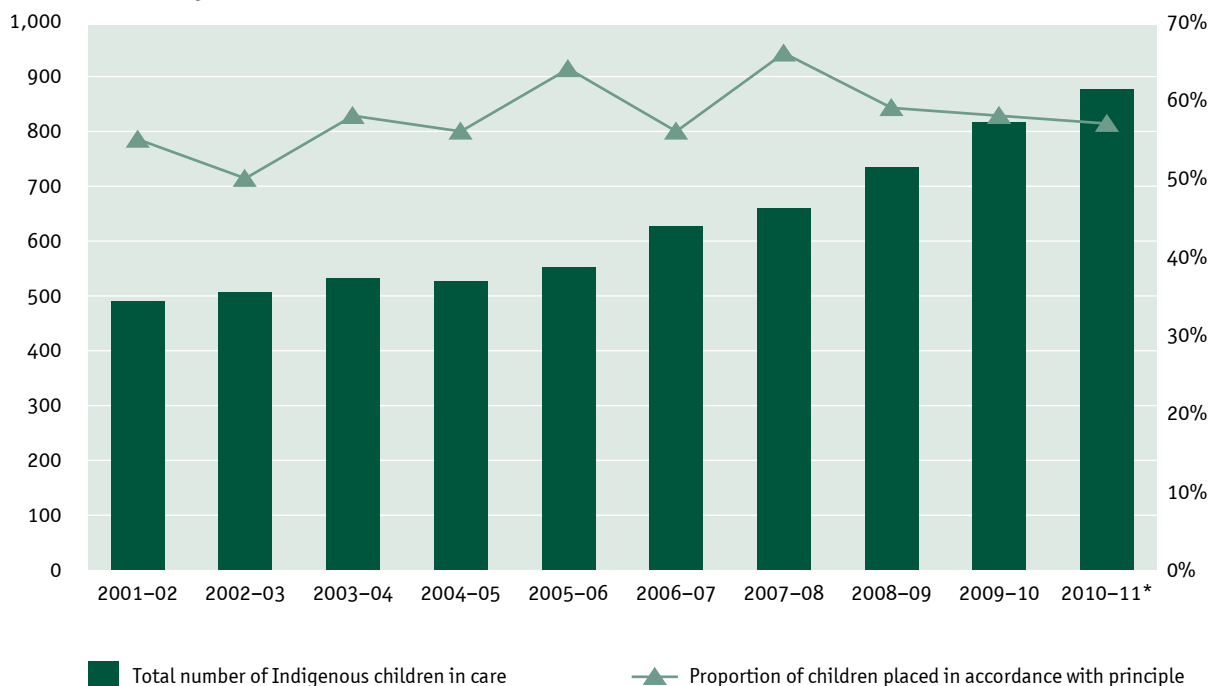
A key factor that results from the relatively young profile of the Victorian Aboriginal community is the proportion of children in relation to the proportion of adults who are potentially available to care for them. This is referred to as the youth dependency ratio. The youth dependency ratio is the percentage of the population under 15 years divided by the percentage of the population aged 15 to 64 years, which includes potential carers. In 2006 in Victoria the youth dependency ratio for the Aboriginal community was significantly higher (0.68) than for the non-Aboriginal population (0.28) (AIHW 2011a, pp. 1,104, 1,105).

As Figure 12.3 illustrates there has been little progress in Victoria in the improving the percentage of children placed in accordance with the ACPP over recent years. Further, Victoria rates fifth compared with other states and territories in complying with the ACPP (see Figure 12.4).

VACCA's Koori Cultural Placement and Support Program

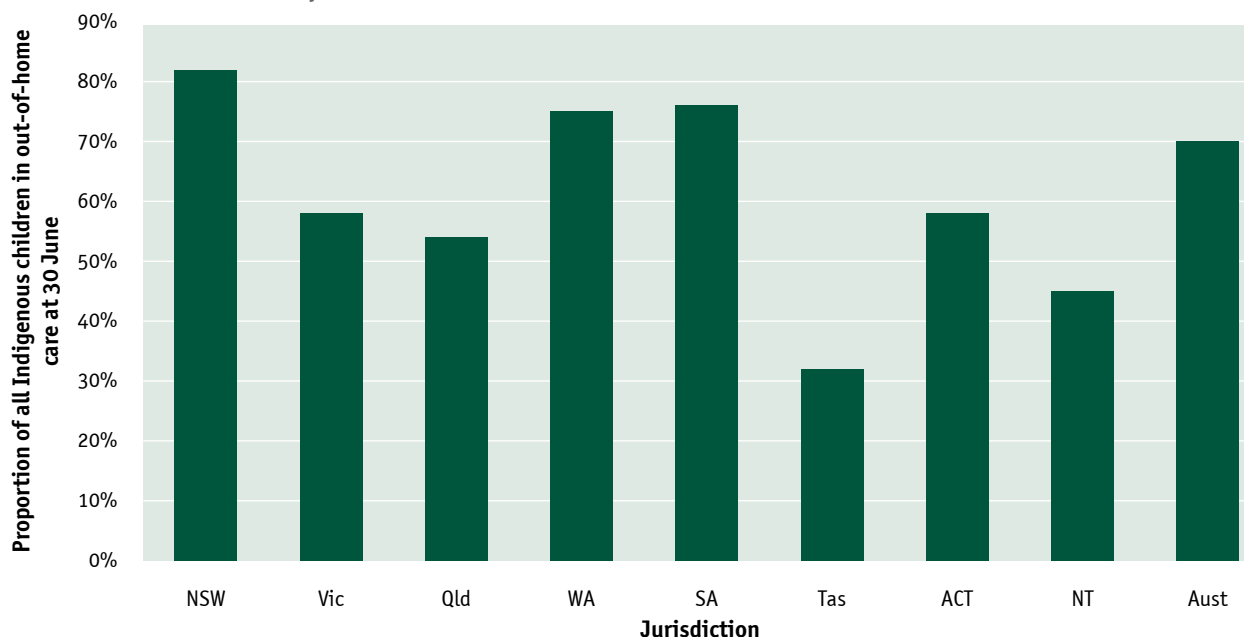
VACCA's Koori Cultural Placement and Support Program works to connect the child or young person placed in out-of-home care to their family and community, and encourage the child to know and take pride in their culture. The program can also work alongside carers assisting them to involve the child in cultural events and introducing them to members of the child's community. To date, the program operates for a small number of Aboriginal children in three regions of Victoria (VACCA submission, p. 54).

Figure 12.3 Aboriginal out-of-home care placements and compliance with the Aboriginal Child Placement Principle, Victoria, 2001–02 to 2010–11



Source: SCRGSP 2011c, Table 15A.62

* Provided by DHS

Figure 12.4 Aboriginal children placed in out-of home care in accordance with the Aboriginal Child Placement Principle, states and territories, 2009–10

Source: SCRGSP 2011c, Table 15A.22

Cultural competence

The impact of disadvantage on a child's development and the history of forcible removal of Aboriginal children has resulted in Aboriginal families being suspicious of health and welfare services. This means that services designed to assist Aboriginal people must pay close attention to how Aboriginal people use the services and provide those services in a culturally competent manner. Cultural competence is defined as the integration of a set of congruent behaviours, attitudes and policies in a system, agency or among professionals and allows that system, agency or those professionals to work effectively in cross-cultural situations (Isaac & Benjamin 1991).

The registration process for community service organisations (CSOs) (see Chapter 21) has a standard related to cultural competence in the provision of services for Aboriginal children, young people and families. The performance of CSOs against the standards are externally reviewed. The *Report of the External Reviews of CSOs against the Registration Standards under the Children, Youth and Families Act 2005*, prepared by DHS (2007–10) records the results from this review process. The report identifies that only 48 per cent of CSOs were rated as having met the standard of respecting Aboriginal children and youth's cultural identity (DHS 2011n, p. 20). Most CSOs subsequently sought to improve their performance against this standard through the inclusion of actions focused on improving cultural awareness. Typically the actions related to:

- Cultural awareness training to be completed by staff and carers and board members;
- Memoranda of understanding to be developed with local Aboriginal community controlled organisations (ACCOs);
- Implementation of the Aboriginal Cultural Competence framework; and
- Ensuring all carers and staff have received training in cultural competency practice and related areas to support the needs of Aboriginal and culturally and linguistically diverse children, youth and families (DHS 2011n, p. 36).

As outlined in Chapter 21 DHS has recently established a Standards and Registration Unit to undertake the registration, monitoring and review of CSOs in integrated family services, out-of-home care, disability services and homelessness support. The unit will monitor the performance of all CSOs against the new DHS standards from July 2012. Particular attention should be paid in the development of the new DHS standards and in the next cycle of registration to the performance of agencies in relation to cultural competence.

Chapter 16 provides further detail relating to the need for cultural competence by the workforce across the broad system to protect vulnerable children.

Recommendation 33

Aboriginal cultural competence should be a feature of the Department of Human Services standards for community service organisations. Further, the performance of agencies in relation to cultural competence should be an area of specific focus in the next cycle of community service organisation registration.

12.6 Sector capacity

ACCOs in Victoria currently provide a range of services on behalf of the Victorian and Commonwealth governments. This section considers capacity and related issues that have arisen during the course of the Inquiry.

12.6.1 Commonwealth and state government expenditure

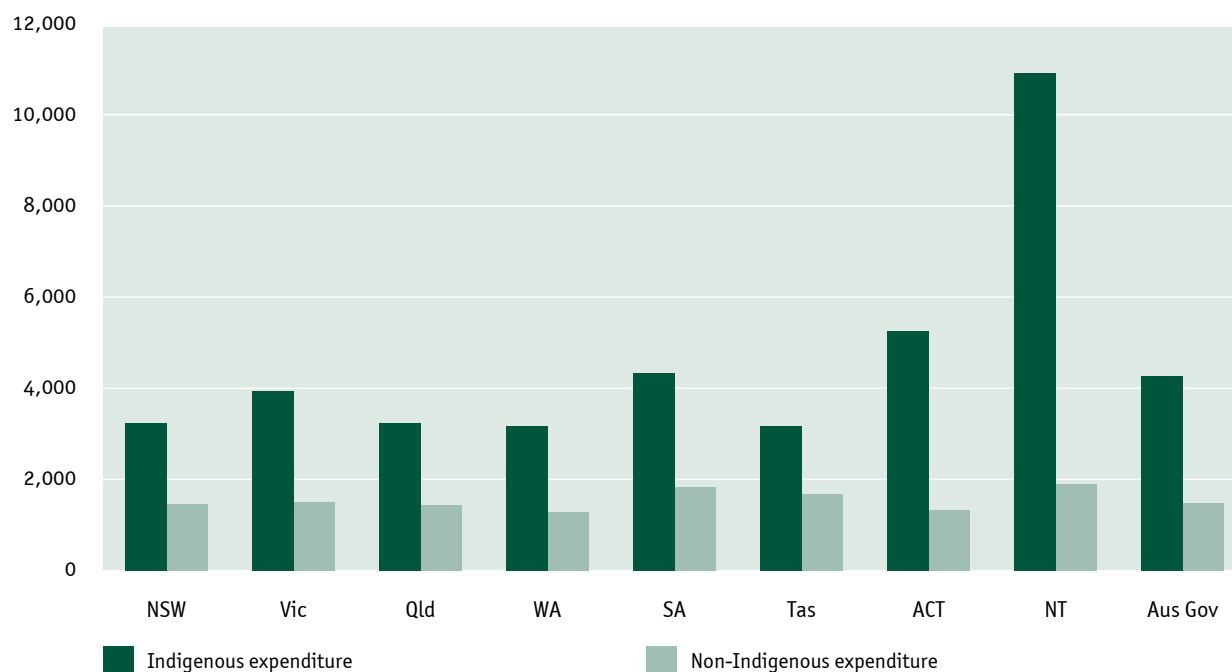
The *2010 Indigenous Expenditure Report Supplement* provides basic data on expenditure by government. It makes no assessment of the adequacy of that expenditure. However, the estimates in the report, when combined with other information (such as levels

of Indigenous disadvantage) can contribute to a better understanding of the adequacy, effectiveness and efficiency of government expenditure on services to Indigenous Australians.

The report identifies that expenditure on services related to Indigenous Australians per capita can be expected to be greater than for non-Indigenous Australians, given their significant relative disadvantage, more intensive use of services, and greater cost of provision (because of factors such as higher representation of the Indigenous population in remote areas) (SCRGSP 2011a, p. iii). Figure 12.5 outlines the expenditure per head of population on safe and supportive communities in 2008-09.

Figure 12.5 includes indirect and direct costs associated with providing safe and supportive communities. In comparison with other Australian jurisdictions Victoria's expenditure per capita is greater than expenditure in New South Wales, Queensland, and Western Australia, which all have large Aboriginal populations.

Figure 12.5 Australian Government expenditure per head of population on safe and supportive communities, by Indigenous status, 2008-09



Source: SCRGSP 2011a

12.6.2 The Aboriginal community controlled sector in Victoria

The ACCO sector is large and diverse. Aboriginal Affairs Victoria (AAV), a unit of the Department of Planning and Community Development (DPCD), provides advice to the Victorian Government on Aboriginal policy and planning and also provides some key programs. DPCD has a central role in managing Victoria's growth and development and building stronger communities. Within this context AAV works in partnership with Aboriginal communities, government departments and agencies to promote knowledge, leadership and understanding about Victoria's Aboriginal people.

AAV also has a lead role in building skills, leadership and capacity within communities and organisations. AAV runs regular governance training workshops tailored for Aboriginal community organisations and designed to strengthen Aboriginal organisations through development of management and governance skills of board members and key staff. In addition AAV provides the Indigenous Community Infrastructure Program, which assists Victorian Aboriginal organisations to acquire, upgrade and develop facilities for community use.

Currently AAV is also working with other state government departments and the Aboriginal community to develop a whole-of-government leadership and capacity building strategy. The strategy will identify and promote innovative approaches to the development of a coordinated range of leadership and capacity building opportunities.

AAV also is instrumental in establishing the Aboriginal representative arrangements and structure in Victoria and works closely with the secretariat to the Ministerial Taskforce on Aboriginal Affairs on the VIAF.

The report *Positioning Aboriginal Services for the Future* identifies that there are approximately 170 ACCOs registered as operating in Victoria. The report provides an overview of the Aboriginal Community Controlled sector in Victoria and represents the views expressed by a broad range of stakeholders (Effective Change 2007).

The sector is very diverse. For example there are:

- Small, medium and large organisations with a focus on health and community services;
- Single service organisations such as the Koorie Heritage Trust and the Aboriginal Housing Board Victoria;
- Statewide organisations such as VACCA;
- Organisations funded for peak body functions such as the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), Victorian Aboriginal Community Services Advancement League (VACSAL) and Victorian Aboriginal Education Association Incorporated;
- Organisations that have been set up to represent the interests of traditional owners;
- Organisations established to support gathering places; and
- A range of other organisations involved in activities such as education, sport, business, arts and crafts, child care and the promotion of Aboriginal culture.

Governance

As community controlled organisations, ACCOs draw their board membership directly from the community they serve. Board members of ACCOs have the challenging role of balancing cultural and community expectations with their legal and fiscal obligations.

As part of the consultations for the *Positioning Aboriginal Services for the Future* project, information was collected about the membership, skills and qualifications of ACCOs' board members. The information collected shows that ACCO board members currently include:

- Elders, community leaders and people employed in a range of jobs including public servants, university lecturers, staff members of other ACCOs, nurses and Aboriginal health workers;
- People with doctorates, degrees and professional qualifications as well as people with basic literacy and numeracy skills or who cannot read or write; and
- People who have attended governance training such as that provided by AAV, as well as a majority of board members who have not received any specific governance training.

Funding sources

In the Aboriginal community controlled sector the majority of organisations are solely dependent on Commonwealth and/or state government funding.

In 2010-11 the largest Victorian funding sources were DHS, which provides approximately \$33.5 million annually to ACCOs for service delivery and the Department of Health which provides \$24.3 million annually. In 2007 the Office for Aboriginal and Torres Strait Islander Health provided funding of \$20 million to Victorian ACCOs. Thirty-three health and community service focused ACCOs receive funding from both the Commonwealth and Victorian governments for health and community services. Most of these ACCOs have to manage multiple sources of funding with a diverse range of reporting, accounting and grant acquittal requirements.

The current system of resourcing Aboriginal organisations creates barriers to good service delivery and better outcomes for Aboriginal children and families. Multiple funding agreements and requirements for detailed submissions place pressure on Aboriginal organisations that do not have the infrastructure to manage these. Program resources usually have a narrow focus, while the needs of Aboriginal children and families are broad and multifaceted. There is little room for negotiation with funding sources and little room for flexibility when the model does not work for Aboriginal children and families who are presenting with highly complex needs and multiple disadvantage (VACCA submission, p. 62).

Capacity

The *Positioning Aboriginal Services for the Future* report concludes that the majority of ACCOs in Victoria have very limited infrastructure and capacity in the areas of management, human resource management and industrial relations, finance, legal, policy and information technology. For example:

- Most ACCOs have extremely flat management structures, with staff from a variety of program areas reporting directly to the chief executive officer. Only a handful of organisations have a management team, and 12 organisations employ only one person in a management position.
- Only a handful of organisations have the resources to employ specialist staff such as a human resources manager, information technology manager, policy officers, training coordinators etc. In fact, the five largest organisations employ 64 per cent of all specialist staff.

Aboriginal organisations have difficulty in attracting, supervising and supporting appropriately qualified Aboriginal staff. This is in part because of the small number of Aboriginal people with appropriate skills and the preference of most organisations to employ Aboriginal people. Consistent with the *Positioning Aboriginal Services for the Future* report findings, submissions (VACCHO, p. 9; VACCA, p. 60; VACSAL, p. 6; Aboriginal Family Violence Prevention Legal Service Victoria (AFVPLSV), p. 11) to the Inquiry noted that the challenges for ACCOs providing child and family services included the following:

Developing the professional capacity of our Aboriginal workforce includes staff in child and family welfare and organisational development areas, such as finance and human resources management.

In the long term, programs which encourage Aboriginal participation in tertiary education for social work, community development, finance and human resource management are necessary to break down the dependence of Aboriginal child welfare agencies on non-indigenous professionals, government departments and mainstream organisations (VACCA submission, p. 60); and The *Positioning Aboriginal Services for the Future* project developed plans about what changes organisations and Governments might wish to make in order to ensure that ACCOs would be able to operate effectively over the next five to ten years. This report is one of a number where good plans made with Aboriginal services have not been implemented (VACCA submission, p. 60).

One of the key factors in retaining staff is having an appropriate work-life balance. This can be difficult for Aboriginal staff who are often part of the community they work in, facing the same issues of grief, loss and trauma that they are seeking to address (VACCA submission, pp. 59-60). As stated in one submission:

Aboriginal workers who provide support for families often have little support regarding child protection issues. Non-Aboriginal colleagues have limited understanding about the unique position these workers hold in Aboriginal communities (East Gippsland Discussion Group submission, p. 3).

The joint submission from Anglicare Victoria, Berry Street, MacKillop Family Services, The Salvation Army, Victorian Aboriginal Child Care Agency and the Centre for Excellence in Child and Family Welfare (Joint CSO submission) supported the concept of developing a 10 year plan to build the capacity and coverage of Aboriginal organisations supporting children and families. This was articulated in the VACCA submission as a:

10 year plan to develop Aboriginal organisations so they provide universal, secondary and tertiary services for Aboriginal children and families (VACCA submission, p. 5).

Child and family welfare services

ACCOs are a significant provider of child welfare services for the Aboriginal community in Victoria both for secondary and tertiary services. There are 18 ACCOs providing child and family welfare services funded by DHS. There is an incomplete suite of Aboriginal family support services in areas where there are significant Aboriginal populations. Therefore, the availability and accessibility of Aboriginal family support programs to vulnerable Aboriginal families to provide early assistance with parenting and other issues is limited.

Child and family service providers must be registered and meet registration standards. DHS has provided funding to Aboriginal organisations over the past three years to assist them to meet registration requirements. DHS has advised the Inquiry that all the Aboriginal organisations that provide child and family services have been externally reviewed and re-registered during 2010.

ACCOs providing child and family services are registered and providing \$3.6 million in family services.

12.7 International comparisons

Canada

As is the case in Victoria, Aboriginal children in Canada represent an increasing proportion of people living in Canada and continue to represent a far greater proportion of children in care than do non-Aboriginal children. (Note: in this section the term Aboriginal encompasses First Nations, Inuit and Metis peoples).

Legislation with respect to Aboriginal children differs across Canada's provinces; however, there is a trend towards tripartite negotiated agreements with Aboriginal peoples (Libesman 2004, p. 7). These agreements recognise the specificity of Aboriginal people's children's needs and the benefits of local control over children's services and decision making. In many instances in legislation, but otherwise in practice, the importance of including Aboriginal agencies in all aspects of decision making with respect to Aboriginal children is recognised.

Alongside the legislation in Canada there is a complicated patchwork of child welfare models serving Aboriginal children (National Collaborating Centre for Aboriginal Health 2010, p. 2). The most common models serving Aboriginal children are mainstream services and one of two Aboriginal models: either a partially delegated service delivery model that typically provides support services and guardianship, or a fully delegated service delivery that provides support and child protection services.

When delegation exists it involves the granting of specific powers for a specific purpose. Under a full delegation approach the province delegates the full range of child welfare services to the Aboriginal community or agency. Most Aboriginal people see delegated models as a transition to self-government (National Collaborating Centre for Aboriginal Health 2010, p. 2). Self-government includes not only Aboriginal service delivery but also Aboriginal self-governing authority over policy and funding.

There are 125 First Nations child welfare agencies including fully mandated agencies and agencies that provide partial support services. Outside of cities most First Nations families that live off reserves are likely to be receiving mainstream services.

Linesman considers that the effectiveness of the Canadian arrangements regarding the implementation of Aboriginal control over children's services and decision making is hampered by financial and other resource restraints and in some instances by the ad hoc implementation of reforms (Libesman 2004, p. 7).

In 2010 the Commission to Promote Sustainable Welfare noted that many experts link the inadequacy of funding with the growing numbers of Aboriginal children in care. The Canadian Incidence Study on Reported Child Abuse and Neglect has repeatedly found that Aboriginal children are investigated and their investigations are substantiated at higher rates than non-Aboriginal children. Aboriginal children are more likely to receive ongoing services after a substantiated investigation than non-Aboriginal children and Aboriginal children are more likely to be removed from their home than non-Aboriginal children.

The Commission notes that the significant over-representation of Aboriginal children in substantiated investigations and in child welfare placements has been found to be clearly correlated to the high level of caregiver, household and community risk factors (poverty, substance misuse, family violence, and poor housing conditions). The Commission concludes that if adequate funding was provided, structured in ways that support Aboriginal child welfare providers to target these risks, then there would be some promise of addressing the over-representation of Aboriginal children (Commission to Promote Sustainable Child Welfare 2010a, p. 33).

United States

American Indian children are over-represented in the child welfare system, especially in out-of-home care and non-kinship foster placements. High rates of removals of American Indian children have continued in many US communities despite the requirements of the *Indian Child Welfare Act 1978* (ICWA).

The ICWA is the national legislation that regulates welfare for Native American children in the US (Lucero 2007, p. 4). The legislation transfers legislative, administrative and judicial decision making to Indian bands where children live on a reserve. All state child welfare agencies and courts must follow the law when they are working with Indian families in child custody proceedings.

The ICWA was passed with the dual objective of protecting the best interests of Indian children and to promote the stability and security of Indian tribes, communities and families. The ICWA had two overall purposes:

- To affirm existing tribal authority to handle child protection cases (including child abuse, child neglect and adoption) involving Indian children and to establish a preference for exclusive tribal jurisdiction over these cases; and
- To regulate and set minimum standards for the handling of those cases remaining in state court and in state child social services agencies.

The ICWA is premised on recognition of limited tribal sovereignty and the collective interest of tribes in children. ICWA gives Indian tribes the right to be involved in deciding what should happen for Indian children who may be placed in foster care or adoptive placements. Tribes, state agencies and state courts do not always agree on what the best plan is for Indian children in foster care (McCarthy et al. 2003, p. 81).

ICWA gives state child welfare agencies certain responsibilities to protect parental rights:

- Before state child welfare agencies can take children from their families, ICWA requires the agency to make 'active efforts' to help keep children at home. 'Active efforts' means any kind of direct services and assistance that will help the family stay together. But if the situation is very dangerous, children can be removed immediately until it is safe for them to be returned;

- An Indian parent or Indian custodian and their tribe, must receive 'notice' by registered mail of all of the legal proceedings involving children. If the child must be removed from home, the state child welfare agency and state court must notify the parent and child's tribe(s). This must occur whenever a tribal member is involved in a child welfare proceeding;
- If an Indian parent is not able to afford legal counsel, under the ICWA, they have the right to have legal counsel appointed by the court. If a state does not provide legal counsel, the court is supposed to notify the US Secretary of the Interior. The Secretary is supposed to pay reasonable fees and expenses for legal counsel; and
- Before removing a child from home, the ICWA requires that an 'expert witness' testify in court that this placement is necessary. The expert witness is a person who is American Indian or who is experienced in working with Indian families.

When adopting or fostering Indian children, state courts must follow a preferred order of placement that is similar to the ACPP. The descending order of preference to be followed is: with a member of the child's extended family; with other members of the child's tribe; with another Indian family; and if the above three options are not possible, with a non-Indian family. An Indian child may be removed, under state law, for a limited period of time for emergency placement to prevent imminent physical harm.

Native American child welfare is delivered through a number of agencies including non-government organisations, tribal agencies, and state and federal agencies. Lucero asserts working successfully with American Indian families requires both system-level and direct practice interventions (Lucero 2007, p. 14). The identified system-level approaches include a:

- Focus on early identification of American Indian children at risk;
- Culturally appropriate training of child welfare staff;
- Commitment to kinship placements and supporting extended family systems;
- Commitment to maintaining children's cultural connections; and
- Developing collaborative partnerships to benefit American Indian families (Lucero 2007, p. 25).

Summary

In Canada and the US the child welfare systems responding to child abuse and neglect in First Nations communities face many similar issues to the Victorian system. One common feature of both jurisdictions is the development of mechanisms to include First Nations tribes or bands in decision making concerning Aboriginal children who have been abused or neglected and face removal from their birth family.

The challenges are also consistent with the Victorian experience:

- Growing numbers of Aboriginal children;
- The over-representation of Aboriginal children and families in the statutory child protection services;
- The difficulty of maintaining cultural connection;
- The determination and provision of adequate resourcing; and
- Designing approaches that can systemically accommodate the dual interest of the community or group and the individual rights of parents or the child.

12.8 Consultation

Chapter 1 provided details of the consultation process conducted by the Inquiry. In total, 12 different consultation events occurred including visits to metropolitan and regional Aboriginal organisations, as well as the consultation sessions with Aboriginal communities in Mildura, Shepparton, Dandenong, Warrnambool, Bairnsdale and Thornbury.

Themes raised in the consultations included the need for cultural competence training for child protection workers to understand the trauma from past practices and the psychological impact for previous generations. Participants said that child protection workers must be aware of protocols before entering the community, such as approaching the community before speaking with the families. They said that it is important for child protection workers to build trust and relationships with the community, and that communication had to happen earlier in the process, such as contacting the Aboriginal co-operatives when a child has to be removed.

Similarly, participants said that the community would greatly benefit from culturally appropriate counsellors, services, delivery models and materials, and that DHS should employ more Aboriginal staff and Aboriginal liaison workers in the community.

Another theme raised was the need for more support and communication before a child is removed. There should be stronger focus on prevention and early intervention, and on providing support such as respite care for families and carers in advance, instead of at crisis point. Ideally, parenting support should be available within the community, instead of having to go elsewhere to receive assistance. On that note, participants highlighted that physical access to services was an issue for the community and there was a sense that there was no planning for services in growth areas.

12.9 Inquiry submissions and consultations

Improvements to the various systems intended to support vulnerable Aboriginal children and families were a major focus the submissions and consultations with Aboriginal people during the Inquiry. Suggestions ranged from an increase in Aboriginal self-determination and culturally competent services to more practical matters of increasing school attendance and financial support for carers.

Increase self-determination

Increased self-determination for Aboriginal communities was presented as a foundational requirement to improve outcomes for vulnerable Aboriginal children by Aboriginal organisations and groups. As the VACCA submission noted:

As an Aboriginal community controlled child and family service organisation, we believe that to protect vulnerable Aboriginal children and strengthen Aboriginal families and communities, we need a service system which respects Aboriginal self-determination and embeds Aboriginal culture into service provision (p. 1).

It was proposed that Aboriginal self-determination could be realised through Aboriginal governance, guardianship and the introduction of new mechanisms to oversee and promote systemic change in relation to vulnerable Aboriginal children and families.

New oversight mechanisms

The proposals for new oversight mechanisms included the following proposals:

- Establishing an Aboriginal governance body and an Aboriginal Children's Commissioner (submissions from Berry Street, p. 16; Centre for Excellence in Child and Family Welfare, p. 8; VACCA, p. 4; VACCHO, p. 11);

- The appointment of a Deputy Commissioner for Aboriginal Children with a specific portfolio on Aboriginal children and young people (Joint CSO submission, p. 81; VCOSS submission, p. 57);
- Establishing a Family Lore Council comprised of respected Aboriginal representatives to provide expert advice to the Secretary of DHS as well as undertake a range of functions related to transfer of guardianship (VACSAL submission, p. 8);
- An Aboriginal advisory body to oversee the steps taken to improve outcomes for Aboriginal and Torres Strait Islander children (AFVPLSV submission, p. 27); and
- The regular reporting to forums that act in the interest of the Aboriginal and Torres Strait Islander community including the Aboriginal Justice Forum, the Indigenous Family Violence Partnership Forum and the Regional Aboriginal Justice Advisory Committees (AFVPLSV submission, p. 27).

A key rationale in the submissions advocating for the establishment of an Aboriginal Children's Commissioner was to enable the independent oversight of the Aboriginal specific provisions in the CYF Act and the future development of the systems to support vulnerable Aboriginal children overall. The AFVPLSV considered that what is needed is:

... a process of independent and transparent oversight with respect to the protection and advancement of legal rights and wellbeing of Aboriginal and Torres Strait Islander children and families in the child protection system in Victoria along with capacity for systemic advocacy (AFVPLSV submission, p. 2).

Reduce the gap between policy and legislation and practice

A number of submissions specifically commented on the current gap between policy and legislation and practice (AFVPLSV, p. 9; East Gippsland Discussion Group, pp. 1-2; VACCA, p. 50). The East Gippsland Discussion Group submission stated:

The consultative group's experiences lead us to believe that the child protection legislation and program policies are often ignored, given cursory acknowledgement or in some cases draw discriminatory comments from child protection workers. This would indicate at least varying degrees of effective implementation of legislation and initiatives (pp. 1-2).

Introduction of Aboriginal Children's Commissioner

The provision in the CYF Act that enables the transfer of guardianship of Aboriginal children to the Aboriginal chief executive officer (CEO) of an Aboriginal organisation (known as section 18) received support in the submissions (AFVPLSV, p. 9; VACCA, p. 5; VACCHO, p. 3; VACSAL, p. 8). As VACCHO commented:

VACCHO supports the option of a section 18 placement where the agency and the CEO are resourced sufficiently to make this governance of the child placement effective (VACCHO submission, p. 3).

However, two main areas of concern about section 18 were identified. First, that the provision had not yet been utilised and, second, that there were a range of specific considerations and dilemmas that require further consideration for effective implementation to occur. The introduction of an Aboriginal Children's Commissioner was seen as a means to maintain a focus on initiatives such as the transfer of guardianship and to provide visibility on progress.

Some dilemmas that arise with this provision that were identified as needing further clarity included:

- The concern that the community governance of ACCOs leaves them vulnerable to community backlash at a local level;
- The potential difficulties in protecting the privacy of the individuals concerned;
- That conflicts may also arise about the obligations as a service provider to the family and the policing role of statutory child protection services;
- The service will often be unable to speak publicly about its decisions in order to maintain integrity and confidentiality while the services and decisions critics are able to speak with impunity; and
- For a service provider, taking on responsibilities under section 18 may discourage parents from seeking support when they are in need, for fear of removal of their children (VACCHO submission, p. 5).

The Inquiry notes that Aboriginal community organisations are already preparing for responsibilities under section 18. A working group comprising ACCOs and DHS representatives has been meeting for the past four years to consider implementation issues. Recently there was a study tour to Canada to investigate first-hand how equivalent powers operate in that context.

Statutory child protection services

The performance of statutory child protection services featured prominently in the submissions from Aboriginal organisations and groups. The reaction of many Aboriginal families to statutory child protection services was observed to be fear, distrust and trauma.

The lack of adherence to, or poor progress in implementing, Aboriginal specific provisions in the CYF Act was raised in a number of contexts. It was raised as part of the rationale for an Aboriginal Children's Commissioner and in relation to how some aspects of current operations could be altered or enhanced to overcome current obstacles. The VACCA submission observed:

Legislation that mandates consultation with an Aboriginal organisation about the protection of an Aboriginal child, adherence to the Aboriginal Child Placement Principle and development of cultural support plans for Aboriginal children in out-of-home care have not translated well into practice (p. 19).

In the provision of statutory child protection services the benefit and complexity of providing cultural advice was identified (AFVPLSV submission, pp. 22-23; East Gippsland Discussion Group submission, p. 5; Mungabareena Aboriginal Corporation supplementary submission, p. 1). The role of the Aboriginal Child Specialist Advice and Support Services in Victoria operated by VACCA and Mildura Aboriginal Corporation was discussed in the AFVPLSV submission. The submission noted that:

The introduction of the unique Aboriginal Child Specialist Advice and Support Services in Victoria (ACSASS) through the VACCA has been a progressive step forward. However, community education aimed at clarifying the role of ACSASS, including in relation to the broader role of VACCA and its relationship with DHS child protection, is also urgently needed. In addition, it is clear these services are heavily underfunded to adequately meet the needs of Aboriginal and Torres Strait Islander women and children (p. 24).

This submission also raised the policy dilemma of VACCA providing services in a range of areas including specialist cultural advice to statutory child protection services through ACSASS. It was proposed that greater assurances of confidentiality between the two service streams was required alongside a renewed emphasis on community education (AFVPLSV submission, p. 22).

The benefits of bringing the Aboriginal community and other service providers together to share responsibility for the safety and wellbeing of Aboriginal children were clearly expressed at the Dandenong Aboriginal community consultation:

The best interest of the child is for us to work together as a team (Dandenong Aboriginal consultation).

Successfully involving the Aboriginal community in decision making about Aboriginal children and young people in statutory child protection services through using the Aboriginal Family Decision Making (AFDM) program was identified as a strength that could be further developed. The Victorian Aboriginal Legal Service (VALS) submission commented that:

The AFDM program at Rumbalara is an example of a decision making forum for child protection matters that operates in a spirit of self-determination ... this AFDM program settles issues from a whole of community perspective where collaboration is the key and responsibility for the success of agreed outcomes is shared (VALS submission, p. 4).

Out-of-home care

Consistent with the submissions summarised in Chapter 10 regarding out-of-home care the submissions from Aboriginal groups expressed the need to improve the options, quality and outcomes for children in out-of-home care when it is necessary that Aboriginal children are removed from their homes. VACCA commented:

For Aboriginal children, the State has not been a good enough parent. We need better outcomes for Aboriginal children (VACCA submission, p. 2).

The challenges of providing quality out-of-home care services were discussed in the submissions and a variety of measures were identified to improve performance. This included the provision of immediate financial support for Aboriginal carers, therapeutic interventions, respite care and educational support.

There are some things about caring for a child who has experienced trauma that we cannot control; however we can ensure that there is regular respite for carers, therapeutic support for placements, education support and adequate financial reimbursement (VACCA submission, p. 51).

The ACPP is a nationally agreed standard used in determining the placement of Aboriginal children within their own families and communities where possible. The principle has the following order of preference for the placement of Aboriginal and Torres Strait Islander children:

- Placement with the child's extended family (including non-Aboriginal family members);
- Placement within the child's Aboriginal community;
- Placement with other Aboriginal people; and
- Placement with non-Aboriginal carers.

As outlined in the VACCA submission the ACPP was established to ensure Aboriginal children's connection to their family and culture is promoted as a means of ensuring their safety and wellbeing. VACCA also noted:

... it was never the intent of the ACPP to place children with members of their family or community who presented a danger to them. If we do not protect Aboriginal children from abuse, the legacy will be a new generation of adults/parents who view abuse as normative rather than unacceptable and harmful (VACCA submission, p. 11).

The VACCA submission noted that the intent of the ACPP was for Aboriginal children to remain connected to their Aboriginal culture and community and proposed ways to improve compliance and reinforce the importance of partnership between ACSASS and statutory child protection services. These ideas included:

- Compliance with the legislative requirement to consult with ACSASS and comply with the ACPP is included as a monitored key performance indicator; and
- Child protection staff to be co-located with ACSASS staff within Aboriginal organisations.

Reunification

The importance of maintaining the cultural connection of Aboriginal children who were placed with non-Aboriginal carers through mainstream organisations was also an area identified as requiring continued efforts (VACCA submission, p. 54).

The importance of supporting Aboriginal families and reuniting Aboriginal children with their families after being placed in out-of-home care was highlighted to the Inquiry. The Victorian Aboriginal Health Services (VAHS) submission commented that:

There is insufficient emphasis on reuniting families (p. 4).

At the Thornbury Aboriginal consultation it was stated that when an Aboriginal child is removed the Aboriginal community wants to see more reunifications and clarity about what needs to be done for the children to be placed back with their family.

When Aboriginal children cannot be reunited with their families, establishing permanent arrangements was considered crucial for Aboriginal children. It was put to the Inquiry that the DHS policy guidelines already have timeframes for considering permanent care, but due to staff turnover and workload pressures these timeframes were often not followed.

The role of Aboriginal men in families

The importance of including and working with Aboriginal men was raised during the Inquiry. At the Aboriginal consultation in Warrnambool the role of Aboriginal men in the lives of Aboriginal children and their place in families was discussed and the positive impact of a project called Mibbinbah was brought to the Inquiry's attention (see box). As stated at the consultation session:

Children need fathers and more effort is needed in this area (Warrnambool Aboriginal consultation).

Mibbinbah's vision

Mibbinbah is a project that seeks to enable Aboriginal and Torres Strait Islander males to regain their rightful place in society through creating safe spaces for spirit healing, empowerment, celebration and education and training. Men's Safe Spaces were developed as a model to enable Aboriginal and Torres Strait Islander males to meet and discuss issues of concern to them. This includes discussing depression and anxiety in a non-stigmatising environment. The Men's Safe Places involve the facilitation of men's groups in the local community.

The Mibbinbah Indigenous Men's Project is a participatory action research project that aims to understand the factors that make Indigenous Men's Spaces safe and healthy places for men, and how this might benefit families and communities.

Sharing responsibility

In order to improve outcomes for vulnerable Aboriginal children, young people and families the need to reinforce the shared nature of responsibility across government was identified. As noted by VACCA:

Responsibility for protecting vulnerable Aboriginal children needs to be shared across the community and reflected in service delivery approaches. Universal services in health, education and housing need to see themselves as part of this system (VACCA submission, pp. 22-23).

Early years support

In particular the importance of the early years of a child's life was emphasised. The submissions focused on improving the support to Aboriginal children and families in the early years with an emphasis on identifying at risk families early (Mungabareena Aboriginal Corporation supplementary submission, p. 2; VACCA submission, pp. 6, 28-31; VACCHO submission, p. 4).

The type of support that should be provided to Aboriginal children and families in the early years and who should provide the support was a key subject. Providing more holistic approaches and a continuum of care and support from the antenatal care of pregnant women through to support for parenting and child wellbeing in the early years was generally proposed. The Koori Maternity Service (KMS) was identified as an example of how this continuum of support could be achieved (VACCHO submission, p. 4).

Aboriginal community controlled health organisations role

The VACCHO submission (p. 10) asserted that the community role of ACCHOs means they are well placed to provide leadership in the prevention effort and in the protection of children at risk. It was proposed that every ACCHO needs to be resourced to function as a main source of preventative services.

Holistic approach to family violence

The issue of family violence in Aboriginal communities was discussed in many of the submissions to, and consultations with, the Inquiry. While not accepting family violence in Aboriginal communities, in general submissions sought a more holistic response from all services. This approach is exemplified in the following statements:

There is a punitive approach taken by support services to women who experience family violence in cases where child protection intervention results. Aboriginal and Torres Strait Islander women victims are often being re-victimised by an unhelpful, blaming approach, rather than being supported to deal with and understand the broad ranging impacts of violence (AFVPLSV submission, p. 8); and

The Aboriginal community does not excuse the unacceptable levels of family violence perpetrated by Aboriginal men. All perpetrators of family violence must be held accountable for their actions but also be supported effectively to stop the behaviour and be given the chance to become the man they can be; a warrior, free of anger and disconnection, culturally strong and proud (North Western Metro Indigenous Regional Action Group submission, p. 1).

Distribution of funds

The Inquiry was advised that the funding approaches of government departments can impede the development of timely and effective responses to vulnerable Aboriginal children. VAHS commented that they were unable to attract funds for additional enhanced MCH services due to the funds being distributed based on local government areas and not in relation to the needs of specific groups. VAHS stated that because they operate as a hub for child and family services for Aboriginal mothers from a wide range of localities this should be an effective way to reach vulnerable Aboriginal children (visit to Victorian Aboriginal Health Service).

Education

Another area of significant concern was about the accessibility of education to Aboriginal children and young people. The submissions focused on the need for DEECD to provide more support to Aboriginal children and families and more focus on the role of culture in education. It was highlighted that both Aboriginal children and their families require increased support from schools in order to participate successfully, make educational transitions and achieve:

There is a need for increased support for children in schools to support their participation and performance in order to build a foundation of success at school, to keep children and families connected to schools and to assist school retention (VACCHO submission, p. 5).

The East Gippsland Discussion Group was particularly concerned about DEECD providing appropriate support for Aboriginal adolescents:

Local anecdotal reports that indicate Aboriginal adolescents are school refusing from early adolescence and seem to be ignored by primary and secondary schools, and Department Education and Early Childhood Development. No action appears to be taken to address non-attendance and ensure that the factors contributing to school refusal are addressed (East Gippsland Discussion Group submission, p. 4).

The fragility and the importance of efforts to maintain a strong focus on the role of culture in education for Aboriginal children was identified by VACCA:

Aboriginal students are spread across Victoria with 73 per cent of all schools having an Aboriginal student. Isolation is exacerbated by schools that do not see a role for culture in education or where school principals face demands from the education department or school communities to focus primarily on literacy and numeracy (VACCA submission, p. 38).

The importance of meeting the educational needs of Aboriginal children in out-of-home care was identified as requiring increased leadership and sustained commitment from DEECD. As the VACCA submission observed:

There are still challenges with schools. Despite the new DEECD/DHS Partnering Agreement launched in 2010, Individual Education Plans for meeting children's needs are normally driven by VACCA rather than the teacher. Any changes to approach are precarious and dependent on individual teacher discretion, rather than being a strong curriculum focus (p. 53).

Family services

As outlined in Chapter 8, family services have an important role in early intervention to support vulnerable families to care for their children safely. The benefit of support services for vulnerable Aboriginal parents was highlighted in the AFVPLSV submission:

In the experience of FVPLS Victoria, mainstream services such as Family First and Child FIRST are effective in assisting the furtherance of voluntary agreement families. In addition, Parenting Assessment and Skill Development Services (PASDS) are extremely beneficial to our clients to provide intensive in home support and on-going teaching skills. The 10-day parenting courses offered by the Queen Elizabeth Centre are particularly helpful to our clients as it is an excellent opportunity to be with staff to gain assistance and provide basic parenting skills (p. 25).

The issue of the reluctance of Aboriginal families to seek help from mainstream Child FIRST was commented upon in the Mungabareena Aboriginal Corporation supplementary submission:

... there are still the same feelings about Child FIRST as there is about child protection. People feel like they are being targeted even if they are sent to Child FIRST (p. 2).

In the Public Sitting at Broadmeadows VACCA staff commented that this was due, in part, to the lack of specific Aboriginal family services:

The effectiveness of an Aboriginal Child FIRST will depend on the range and availability of Aboriginal family services. Aboriginal families comprise 6.3% of families attending family support services. In the North East area, just over one third of these families receive an Aboriginal family service. An Aboriginal Child FIRST service that must refer around two in every three Aboriginal families to mainstream family services may be compromised in terms of achieving its potential (VACCA, Broadmeadows Public Sitting).

Cultural competence of service providers

Another strong theme in the submissions received from Aboriginal organisations and groups was the necessity for mainstream service providers to be culturally competent. Generally the submissions advocated for the provision of mandatory and uniform Aboriginal cultural competence training (AFVPLSV, p. 40; VACCA, p. 26; VACCHO, p. 7; VAHS, p. 4). The AFVPLSV submission argued that:

Uniform and mandatory cultural awareness training would also contribute to better outcomes for Aboriginal and Torres Strait Islander children (p. 36).

As part of demonstrating cultural competence AFVPLSV also discussed the requirement for services to be more flexible in the provision of service:

Our greatest concern with mainstream services is that they need to be more flexible in their intake criteria for Aboriginal and Torres Strait Islander families as well as with their scheduling (AFVPLSV submission, p. 25).

There was a call for the proper application of cultural competence as at times workers may mistakenly accept conduct as culturally appropriate in Aboriginal families that would not be acceptable in non-Aboriginal families.

Due to the over-representation of Aboriginal children in the statutory child protection system some submissions recommended that more Aboriginal staff need to be employed in statutory child protection services and greater attention given to professional development. The Royal Children's Hospital (RCH) Social Work Department proposed that:

... greater priority be given to training and ongoing professional development for Aboriginal staff in this sector. In New South Wales for example, comprehensive training is provided to ensure Aboriginal staff are employed and retained in positions within the Department of Community Services (RCH Social Work Department submission, p. 3).

The Mungabareena Aboriginal Corporation supplementary submission stated that, they need Aboriginal workers or people who have worked with Aboriginal people and are accepted by the community in the statutory child protection services.

Protection for adolescents

The involvement in, and effectiveness of, statutory child protection services for young Aboriginal people was highlighted in the VACCA submission. VACCA informed the Inquiry that that Aboriginal young people aged 15 to 17 are significantly less likely to be statutory child protection clients than at any other time in their childhood:

In 2009/10, they comprised 5.4 per cent of all CP [child protection] substantiations for Aboriginal children compared with 52 per cent for children under five years (VACCA submission, p. 54).

The reason for the absence of young Aboriginal people is not clearly understood; however, the VACCA submission explained that based on its experience, young Aboriginal people often return home at around age 15 after the discharge of a protection order and are then left vulnerable and without sufficient support (VACCA submission, p. 54).

The East Gippsland Discussion Group also raised a range of concerns about providing appropriate support for Aboriginal adolescents at risk. One of these concerns was:

The Ways Forward report (1995) suggests the high rates of incarceration of young Aboriginal people, in part may represent higher rates of conduct disorders amongst Aboriginal young people...Child and Adolescent Mental Health Services in Victoria are very poorly equipped to provide effective therapy for conduct disorders and often are limited in providing culturally appropriate care (East Gippsland Discussion Group submission, p. 5).

12.10 Conclusion

As this chapter has outlined, vulnerable Aboriginal children are at heightened risk of abuse and neglect due to the prevalence of a range of risk factors in the Aboriginal community. As evident from the key data presented in section 12.5.2 and in the summary of the submissions to the Inquiry in section 12.9, significant improvement in the performance of systems that are intended to support vulnerable Aboriginal children and families is needed.

Achieving change in the outcomes for vulnerable Aboriginal children and families is a whole-of-government task, with the responsibility crossing over many areas of state government activity in addition to a significant Commonwealth Government role. The depth of the challenge to achieve improvement in the outcomes for vulnerable Aboriginal children is acknowledged at a national and state level through the existing policy frameworks.

COAG and the Victorian Government have established comprehensive approaches through the COAG *National Indigenous Reform Agreement* and VIAF to address areas of significant disadvantage that are consistent with improving the risk factors that would prevent child abuse and neglect. As outlined in section 12.4 the Inquiry affirms the VIAF and associated structures as the primary mechanism to drive action across government on the broad range of risk factors associated with Aboriginal children being at greater risk of abuse and neglect. Further, the Inquiry has recommended more detailed monitoring should be developed for the VIAF that provides reports on outcomes at the operational level regarding key areas of disadvantage.

Within the systems of early years, education, family services and statutory child protection services (including out-of-home care), Aboriginal children are experiencing very poor outcomes. These poor outcomes suggest the need for the development of specific Aboriginal responses to identify different ways to assist vulnerable Aboriginal children and improve outcomes. The adoption of specialist responses that can accommodate the special needs of the Aboriginal community is required to improve outcomes for children. Where specialist responses have been developed but outcomes for children are not improving it is essential that the responsible agencies analyse the reasons, engage with the Aboriginal community to develop alternative approaches (including funding arrangements), and make the necessary changes to the service responses and evaluate the impact of the service changes.

In light of the levels of disadvantage in the Aboriginal community, the growing numbers of infants and children and the service access issues for Aboriginal communities, one service delivery area that requires immediate consideration is the provision of enhanced MCH services to vulnerable Aboriginal children and mothers.

Education is a key area where outcomes for Aboriginal children require significant improvement. Educational participation and achievement are an essential part of meeting the needs of vulnerable Aboriginal children and young people and is vital for addressing social disadvantage.

Most importantly the educational achievement of Aboriginal children and young people is unacceptably lower than for non-Aboriginal students and it is DEECD's responsibility to develop strategies and interventions to improve this for Aboriginal children and young people at all year levels. It is concerning that Aboriginal children commencing school are significantly more vulnerable than their non-Aboriginal peers. This is an important area to tackle because this early vulnerability will influence educational outcomes over many years.

Improving education outcomes for Aboriginal children and young people is a key focus of the COAG *National Indigenous Reform Agreement* and the VIAF. It is considered that the strategies and interventions that DEECD employ should be measured, monitored and publicly reported in detail. It is considered by the Inquiry that, given the levels of disadvantage in Aboriginal communities in Victoriam, DEECD should adopt a place based approach to target strategies and measure progress.

Another area of significance is providing early support to vulnerable Aboriginal children and families. It is likely that the number of Aboriginal families participating in family services could be higher if there were not the historical barriers to engagement and if Aboriginal family services were available in all areas with significant Aboriginal populations. One of the identified barriers to the provision of this is the incomplete suite of support services in areas where there are significant Aboriginal populations. The availability and accessibility of Aboriginal family support programs and the community nature of ACCOs increases the likelihood Aboriginal families will seek help early to assist with parenting and other issues. It is considered important that this situation is remedied.

It is also clear that many vulnerable Aboriginal children and families will continue to receive a range of services from mainstream providers. As outlined in the submissions the cultural competence of mainstream service providers and child protection is critical to effectively engaging with and helping vulnerable Aboriginal children and families. As outlined in section 12.5.2 and in Chapter 16 on workforce issues, the Inquiry makes a number of recommendations to improve the cultural competence of mainstream providers.

In relation to statutory child protection services and out-of-home care, the numbers of Aboriginal children continues to be unacceptably high. However, it is acknowledged that the ability of statutory child protection services to address entrenched disadvantage is limited. Therefore, it is considered that renewed efforts to create an improved service responses are needed for the large numbers of Aboriginal children within statutory child protection services (including out-of-home care).

As part of these renewed efforts it is proposed that programs and approaches that are currently effective are continued and expanded. This includes use of programs such as ACSASS, AFDM and Aboriginal kinship care support.

Recommendation 34

The Government should expand the use and effectiveness of culturally competent approaches within integrated family services and statutory child protection services, through the Department of Human Services by:

- Establishing funding arrangements with the Aboriginal Child Specialist Advice and Support Service that enable cultural advice to be provided across the full range of statutory child protection activities;
- Using the Aboriginal Family Decision Making program as the preferred decision making process if an Aboriginal child in statutory child protection services is substantiated as having suffered abuse or neglect;
- Expanding family preservation and restoration programs so they are available to Aboriginal families in rural and regional areas with significant Aboriginal populations;
- Expanding Aboriginal kinship care support to provide support to all Aboriginal kinship carers; and
- Expanding Aboriginal family support programs so they are available to Aboriginal families in areas with significant Aboriginal populations.

In Chapter 16 the Inquiry recommends that statutory child protection services develop recruitment strategies to attract suitable candidates from Aboriginal backgrounds.

The Inquiry considers that there are two areas in relation to vulnerable Aboriginal children and young people where specific regular system oversight is required.

First, the implementation of specific provisions in the CFY Act, including cultural support plans, the ACPP and section 18, require increased transparency. Second, in key areas such as education and statutory child protection services, where progress is slow or hard to achieve, service development and performance reporting requires a consistent and sustained focus.

The Inquiry considers that the creation of a dedicated Aboriginal Children's Commissioner or Deputy Commissioner is necessary to address these two areas. This position would bring an increased focus to improving outcomes for vulnerable Aboriginal children in Victoria through monitoring, measuring and reporting publicly on progress against objectives for vulnerable Aboriginal children across all areas of government activity.

Recommendation 35

As part of the creation of a Commission for Children and Young People, an Aboriginal Children's Commissioner or Deputy Commissioner should be created to monitor, measure and report publicly on progress against objectives for vulnerable Aboriginal children and young people across all areas of government activity, including where government provides resources for non-government activities.

As part of renewed efforts to create an improved service responses for the large numbers of Aboriginal children within statutory child protection services (including out-of-home care) the Inquiry has considered a number of structural adjustments. First, it is considered that more effective outcomes for vulnerable Aboriginal children are likely to be achieved with greater Aboriginal self-determination in relation to vulnerable Aboriginal children. As part of this revitalising the efforts to implement section 18 in the CYF is considered a priority. While it is recognised that there are still a number of important and complex issues that need to be resolved in relation to this provision, making progress in this area is important. A clear strategy is required to establish a transparent process that seeks to delegate the guardianship of Aboriginal children removed from their families to Aboriginal communities.

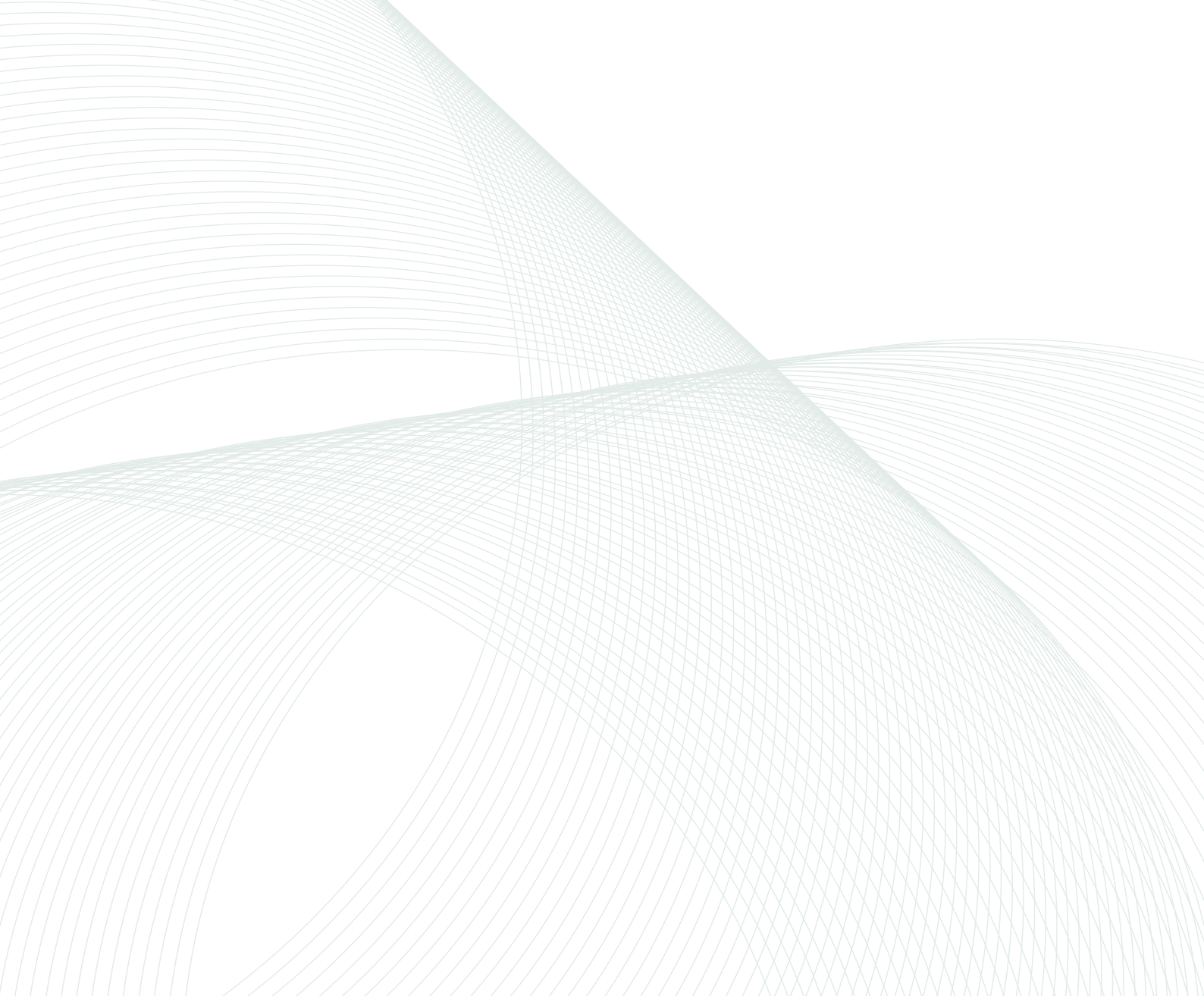
Second, given that the number of children per adult is much higher in the Aboriginal community than in the non-Aboriginal community, and given the much higher proportion of Aboriginal children in care, this inevitably means it will be harder to find Aboriginal caregivers for Aboriginal children. When one considers the health status of many of the Aboriginal adults, and the burden of caregiving and social disadvantage that may already carry, it is highly likely that many Aboriginal children will continue to be placed with non-Aboriginal caregivers. In these circumstances maintaining the cultural connections of Aboriginal children is crucial. Therefore, it is considered that a progressive plan of transferring responsibility for the out-of-home care placements of Aboriginal children in non-Aboriginal placements to ACCOs will both enhance self-determination and provide a practical means to strengthen the cultural links for those children.

Recommendation 36

The Department of Human Services should develop a comprehensive 10 year plan to delegate the care and control of Aboriginal children removed from their families to Aboriginal communities. This would include:

- Amending section 18 of the *Children, Youth and Families Act 2005* to reflect Aboriginal community decision making processes and address current legislative limitations regarding implementation;
- Developing a sustainable funding model to support transfer of guardianship to Aboriginal communities that recognises the cost of establishing an alternative guardianship pathway. These arrangements would initially be on a small scale and require access to significant legal advice, legal representation, practice advice, specialist assessments and therapeutic treatment;
- Developing a statewide plan to transfer existing out-of-home care placements for Aboriginal children and young people from mainstream agencies to Aboriginal community controlled organisations and guide future resource allocation (with performance/registration caveats and on an area basis);
- Providing incentive funds for Aboriginal community controlled organisations to develop innovative partnership arrangements with mainstream providers delivering out-of-home care services to Aboriginal children to connect them to their culture;
- Targeting Aboriginal community controlled organisations capacity building to these activities i.e. guardianship, cultural connection and provision of out-of-home care services; and
- Providing increased training opportunities for Aboriginal community controlled organisation staff to improve skills in child and family welfare.

The proposed Aboriginal Commissioner or Deputy Commissioner for children and young people should report on performance against this plan.



Part 4: Major protective system elements

Chapter 13:

Meeting the needs of children and young people from
culturally and linguistically diverse communities

Chapter 13: Meeting the needs of children and young people from culturally and linguistically diverse communities

Key points

- Victoria's multicultural society consists of more than 230 countries from around the world. Some migrant families experience challenges in parenting, and in trying to adapt to Australian norms and laws.
- Research indicates that there are cultural, structural and service-related barriers that ethnic minority families experience when they migrate to a new country. Migrants can experience hardships and stressors that can impinge on their ability to provide good care for their children.
- These factors are compounded by the challenges of parenting in a new culture. Many culturally and linguistically diverse families may not understand or necessarily agree with all of Australia's law and norms about gender equality, child rearing and parenting.
- There is a lack of data about culturally and linguistically diverse children and young people and their interaction with Victoria's system for protecting children.
- It is important to develop culturally appropriate policies and programs that uphold the rule of law in Victoria and Australia, yet recognise the importance of the values, beliefs, culture and background of different communities. There is a need to better integrate migrants through positive parenting and education programs about Australian culture and norms.
- Victorian child protection services intervene when child abuse and neglect is suspected. It is important that the family services and child protection workforce is culturally competent when managing these interventions with culturally and linguistically diverse communities.
- The Inquiry recommends that data be collected to help determine whether services currently provided are culturally appropriate. Recommendations are also made about including issues relating to culturally and linguistically diverse children in the Council of Australian Governments' national framework.

13.1 Introduction

The exact numbers of children and young people from culturally and linguistically diverse backgrounds involved in Victoria's system for protecting children is not known. There is no mandatory requirement for Department of Human Services (DHS) child protection practitioners to record a child's or young person's ethnicity when a report of child abuse and neglect is made. Completion of data fields such as the child's or parents' country of birth, or main language spoken at home other than English, or the child's cultural ancestry identity, is not mandatory. Analysis of 'country of birth' data from child protection reports in 2009–10 conducted for the Inquiry showed that this field was recorded in only 2 per cent of reports (unpublished DHS data). Due to the very small sample, the Inquiry has concluded that this data is not of sufficient quality to be useful in analysis about the number of children from culturally and linguistically diverse communities who are in Victoria's system for protecting children, and how they are treated.

However, the Inquiry did hear from members of culturally and linguistically diverse communities through its consultation processes and has considered the available research. Both suggest there are matters that need to be addressed. As part of one of the most culturally, linguistically and religiously diverse nations in the world (Victorian Government 2011d), with a sizeable migration program and international obligations to provide asylum for refugees, Victoria receives many families from around the world. Logic suggests these families may experience difficulties in settling in a new land and, without appropriate support, their children may become vulnerable to abuse and neglect.

Cultural diversity

For the purposes of this Inquiry, the term 'culturally and linguistically diverse' refers to a person who is born either overseas or in Australia, and whose parents originate from a country where English is not the main language at home.

Victoria's cultural diversity is reflected in the fact that of a population of 4,932,234 at the time of the 2006 Census:

- 23.8 per cent (1,173,204) were born overseas in more than 230 countries;
- 43.6 per cent (2,152,279) were born overseas or had at least one parent born overseas;
- 72.8 per cent (853,966) of those born overseas came from a non-English speaking background;
- 20.4 per cent (1,007,435) speak a language other than English at home;
- Approximately 20 per cent of Victoria's population aged 17 years of age or younger speak a second language at home (Australian Bureau of Statistics (ABS) 2006b); and
- 68.7 per cent (3,390,804) identify themselves as members of one of 120 different types of religions (ABS 2006b, in Victorian Multicultural Commission 2009, p. 10).

Migrants arrive in Victoria under different circumstances. In 2010–11, more than 21,000 people arrived to settle in Victoria. Of these almost 25 per cent were children and young people under the age of 18. The largest group of migrants (44.8 per cent) arrived under skilled migration or other workforce related programs; 41.5 per cent related to family reunification and 13.7 per cent were under the humanitarian category (Table 13.1). While not all of these migrants are likely to be of culturally and linguistically diverse background it can be expected that many are.

Table 13.1 Overseas migrant arrivals by migration category, Victoria, 2010–11

Type of migration	Adult population (18–65+)	Children and young people (0–17)	Total entrants
Family	7,531	1,397	8,928 (41.5%)
Skilled or workforce	6,855	2,772	9,627 (44.8%)
Humanitarian	1,749	1,186	2,935 (13%)
Total	16,135	5,355	21,490 (100%)

Source: Department of Immigration and Citizenship (DIAC) 2011a

13.2 Challenges for newly arrived families of culturally and linguistically diverse backgrounds

Migrants travel to new lands in search of opportunity for themselves and for their children. Families of culturally and linguistically diverse backgrounds bring different cultural experiences, religious faiths and societal norms when emigrating to Australia. This may present a number of challenges in parenting in a new culture. Furthermore, parents of culturally and linguistically diverse backgrounds may not understand or necessarily agree with all of Australia's laws and norms about gender equality, child rearing and parenting, for example, with respect to discipline or giving a child responsibility for the care of a younger sibling.

Research into African migrant families coming to Australia, for example, examined how parenting in a new culture is a pressing challenge for these families that often leads to family conflict (Renzaho 2009). This research highlighted issues that arise when two differing parenting styles collide. African migrant families come from a culture based on an authoritarian parenting style that centres on the collective family, respect of elders, corporal punishment and interdependence. Traditional gender roles and strong patriarchal structures are also common (The Victorian Foundation of the Survivors of Torture & Horn of Africa Communities Network Inc. 2007). This is in contrast to the Australian parenting style that promotes the individual, self-determination, independence and where the public debate on corporal punishment includes some suggestions of making smacking illegal, reflecting community ambivalence about this form of discipline.

A limited awareness of Australian child rearing norms and child protection laws may increase the likelihood that newly arrived culturally and linguistically diverse families come to the attention of child protection authorities. Many newly arrived migrant families find themselves with competing cultural priorities – that of their cultural heritage and Australian norms and rule of law.

Victoria has laws protecting children and young people that are related to Australian cultural norms. In relation to some norms, there have been very significant intergenerational changes, for example, a reduction in the use and acceptance of physical discipline. The degree of physical punishment that a parent or carer can use with a child is subject to legal regulation in Australia. In most states and territories, corporal punishment by a parent or carer is lawful, provided that it does not cause physical injury and is carried out for the purpose of correction, and that it is 'reasonable' having regarded the child's age and method of punishment. The Inquiry believes that cultural misunderstandings and sensitivities to cultural differences cannot mean that culturally and linguistically diverse children should be less protected in the way required by Australian law.

Many families of culturally and linguistically diverse backgrounds settle smoothly in Australia, however, some culturally and linguistically diverse families are highly vulnerable, particularly newly arrived refugees.

Refugees

Refugees often suffer physical, emotional and mental scars from their experiences of torture and trauma in their country of origin. They may have experienced war, famine, persecution or a range of other dangerous circumstances, including living and surviving in refugee camps for lengthy periods of time. Each year there are approximately 3,000-3,500 humanitarian entrants (refugees) in Victoria, most recently from the Horn of Africa, the Middle East and Afghanistan (Victorian Refugee Health Network 2010).

Australia is a signatory to the United Nations 1951 *Convention relating to the Status of Refugees* (the Refugees Convention) and is one of the few countries that take part in the United Nations High Commissioner for Refugees resettlement program, accepting quotas of refugees on an annual basis. The settlement experience for many refugees can be a very difficult time, with feelings of homesickness, isolation and culture shock having an impact on people's ability to start a new life in Australia.

This may be compounded by a background of poverty, low levels of formal education, and little or no knowledge of English. Their day-to-day existence before arriving in Australia may have been in a refugee camp and they may have no familiarity with aspects of life in a developed economy, for example, renting a house. Other factors that may increase vulnerability, include:

- Experience of psychological trauma (due to persecution, imprisonment or war);
- Experience of being a widow (most refugees are female-headed households);
- Culturally accepted views on family violence;
- Housing issues;
- Unemployment;
- Health issues;
- Language barriers; and
- Social isolation.

This was conveyed by a verbal submission to the Inquiry when Ms Marantelli stated that many refugee families that come to Australia from African and Middle Eastern countries have common experiences of trauma, dislocation and poverty. For many of these families, parenting styles that were normative in their countries of origin are not endorsed in Australia. Refugee families are also often bewildered and confused about the role of government in family life. In their home countries, governments rarely intervene in family matters, which are usually resolved by elders within the family unit, or by religious and community leaders. As a result, many people from culturally and linguistically diverse backgrounds experience significant challenges and barriers (Ms Marantelli, Melbourne Public Sitting).

13.3 Factors that impact on the vulnerability of children from culturally and linguistically diverse communities

While Australian and Victorian law and cultural norms are the environment in which children and young people are protected from harm, knowledge of the cultural beliefs and practices of different communities improves understanding of the potential vulnerability of children and of appropriate service responses.

Korbin has identified the cultural factors that are likely to increase or decrease the incidence of child abuse and neglect:

- Cultural value of children – when a culture values its children because they are bearers of tradition, because they perpetuate the family or lineage, and because of their economic contributions, they are likely to be treated well;
- Beliefs about specific categories of children – a cultural group may value children, but not necessarily all children. Some children may be considered inadequate or unacceptable to cultural standards and as a result fail to receive the same standard of care according to children in general;
- Beliefs about age capabilities and development stages of children – cultures vary in terms of the age at which children are expected to behave in certain ways. The age at which children have a sense of self may vary under different cultural beliefs, therefore punishment before the age of wrong-doing would be pointless; and
- Embeddedness of child rearing in family and community networks – a network of concerned individuals beyond the biological parents is a powerful deterrent to child abuse and neglect. If the community or a wide variety of individuals are concerned about the wellbeing of children, general standards of child care are more than likely to be ensured (Korbin 1981, pp. 205-209).

Very little research has been undertaken in Australia into specific cultural groups or cultural issues in Australian child protection. Relevant studies have been conducted in South Australia and New South Wales.

In 2005 the South Australian Department for Families and Communities commissioned the Australian Centre for Child Protection to examine the extent to which newly arrived refugee families were coming into contact with the child protection system and the issues and influences that brought them into contact with this system. The *Working with Refugee Families Project* found that the most predominant types of incidents and factors that contributed to child protection reports were concerned with alleged physical abuse, family violence and leaving children alone without adult supervision (supervisory neglect).

In 2007 the New South Wales Department of Community Services commissioned a large-scale research project on how to best meet the cultural and linguistic needs of children and families in the child protection system (Sawrikar 2009). The research comprised a review of international literature, which identified that the hardships and stressors migrants experience can impinge on their ability to provide good care for their children. Having an awareness of these stressors can help increase service sensitivity to their cultural needs. The stressors include:

- Migration stress – language barriers, financial insecurity, employment and housing, a lack of traditional support mechanisms such as family and friends, and racism or misunderstandings due to cultural differences;
- Acculturative stress – the conflict between cultural preservation and cultural adaptation;
- Displaced sense of belonging and cultural identity – a feeling of difference from other Australians because of cultural practices and beliefs, language, race, physical appearance, religion and skin colour;
- Racism and discrimination; and
- Intergenerational conflict – conflict between children and their carers can result if children reject traditional values and integrate with the local culture, which can bring culturally and linguistically diverse children to the attention of the child protection system (Sawrikar 2009).

Sawrikar identified three main hypotheses to explain why minority ethnic groups are over-represented internationally in child protection systems:

- Rates of abuse or neglect are higher in these culturally and linguistically diverse groups. The implication of this hypothesis is that a difference in culture is the cause of abuse or neglect, and which then introduces them into the child protection system;
- The increased likelihood of coming to the attention of child welfare agencies because of socioeconomic disadvantage. The implication of this hypothesis is that poverty, and not culture, reflects a systematic bias that introduces them into the child protection system; and
- Culturally inappropriate or insensitive service delivery. The implication of this hypothesis is that culturally biased institutional processes and organisational practices introduce culturally and linguistically diverse families into the child protection system (Chand & Thoburn 2005; Korbin 2002, in Sawrikar 2009, p. 9).

Importantly, this Inquiry is unable to identify whether reporting rates of abuse or neglect are higher in culturally and linguistically diverse communities or not due to the lack of data as identified in section 13.1. The absence of data about culturally and linguistically diverse children and young people and their interaction with the system for protecting children means that the extent of the problem of child abuse and neglect in culturally and linguistically diverse communities is unknown. This is not unique to Victoria and is an issue throughout the country. Previous inquiries into child protection have not addressed this issue. Importantly, lack of data also means there is no empirical evidence to inform system-level policy changes or service responses.

Submissions to the Inquiry have commented on the lack of data on culturally and linguistically diverse families and their interaction with Victoria's system for protection children.

... the number of children and young people from culturally and linguistically diverse backgrounds coming to the attention of child protection authorities is unknown, that is across Australia, not just Victoria. It is not because culturally diverse families are not being reported to authorities, it is predominately because departments do not record demographic information of culturally and linguistically diverse families, yet they are able to record the status of Aboriginal and Torres Strait Islander families (Ms Kaur, Melbourne Public Sitting).

... available data is structured in such a way that it is difficult for those working with migrant and refugee young people to drill down and establish the extent of the representation in Victorian child protection system, as well as how they are faring in regards to their physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, communication skills and general knowledge (Ms Marantelli, Centre for Multicultural Youth, Melbourne Public Sitting).

As outlined in Chapter 4, the absence of data is an issue across the system. The Inquiry considers that it is important to address this data shortage as it is possible that vulnerability, and therefore the risk of abuse and neglect, is higher in some culturally and linguistically diverse communities than for the population as a whole.

Recommendation 37

To improve knowledge and data on vulnerable children of culturally and linguistically diverse backgrounds so that the appropriateness of current service provision can be considered:

- The Department of Human Services should collect data to record and track children and young people of culturally and linguistically diverse backgrounds who are involved with the child protection system, and the family services sector; and
- The Department of Education and Early Childhood Development should include data on the experiences of vulnerable children and young people of culturally and linguistically diverse backgrounds (including in Victoria's system for protection children) in *The State of Victoria's Children* report.

13.4 Legislative context

A number of Victorian statutes safeguard cultural diversity in Victoria while upholding the rule of law, the rights of children and outlining processes relating to their protection from abuse or neglect. The *Multicultural Victoria Act 2011* (MV Act) sits alongside the *Charter of Human Rights and Responsibilities Act 2006*, and the *Children, Youth and Families Act 2005* (CYF Act) in protecting the cultural rights and preserving cultural identity of culturally and linguistically diverse children in Victoria's system for protection children.

The MV Act enshrines a number of key principles under Section 4 that include:

- An entitlement to mutual respect and understanding regardless of background;
- A duty on all Victorians to promote and preserve diversity within the context of shared laws, values, aspirations and responsibilities; and
- A responsibility for all Victorians to abide by state laws and respect democratic processes.

The principles of multiculturalism in the MV Act most pertinent to protecting vulnerable children and their families from a culturally and linguistically diverse background are:

- Section 3 (e) – all individuals in Victoria have a responsibility to abide by the state's laws and respect the democratic processes under which those laws are made; and
- Section 4 – the Parliament further recognises that Victoria's diversity should be reflected in a whole-of-government approach to policy development, implementation and evaluation.

The MV Act also requires the preparation of cultural diversity plans by government departments that outline key developments relating to service provision to culturally and linguistically diverse communities. In summary, these provisions provide that diversity should be preserved, promoted and reflected in whole-of-government policy and implementation, and all Victorians should abide by the state's laws.

Under section 19 (1) of the *Charter of Human Rights and Responsibilities Act 2006*, all people from different cultural, religious, racial or linguistically diverse backgrounds must not be denied the right to enjoy his or her culture, to practise his or her religion, or use his or her language.

Under Section 10 of the CYF Act, the best interests of a child must always be paramount when making a decision, or taking action. These best interest principles apply to all children, no matter what their background. In addition consideration must be given to the child's cultural identity and religious faiths (if any) and, where a child with a particular cultural identity is placed in out-of-home care with a caregiver who is not a member of that cultural community, the desirability of the child retaining a connection with their culture.

Section 11 of the CYF Act requires the provision of information in the appropriate language, the provision of interpreters and the attendance of cultural supports during the statutory child protection intervention process. In particular the Secretary of DHS or community service must consider:

- That those involved in the decision making process should be provided with sufficient information, in a language and by a method that they can understand, and through an interpreter if necessary, to allow them to participate fully in the process (subsection (h), CYF Act); and
- If a child has a particular cultural identity, a member of the appropriate cultural community who is chosen or agreed to by the child or by his or her parents should be permitted to attend meetings held as part of the decision making process (subsection (i), CYF Act).

Section 176 of the CYF Act provides a mandatory requirement to develop cultural plans for Aboriginal children entering custody and guardianship orders. Cultural plans for Aboriginal children and young people enshrine the importance of being connected to their community and culture. The plans aim to educate children and young people about their heritage and provide them with a sense of belonging. In contrast, there is no mandatory requirement under the CYF Act for cultural plans for children and young people from culturally and linguistically diverse backgrounds – they are prepared at the discretion of the case worker. While no data is available, it is estimated that currently only a small minority of children and young people from culturally and linguistically diverse backgrounds have cultural plans. In ideal circumstances, best outcomes are also achieved by building partnerships with ethnic organisations to assist DHS in the development of cultural plans for culturally and linguistically diverse families.

The CYF Act also provides for the Minister for Community Services to determine performance standards for registered community service organisations (CSOs). The following standards applying to CSOs under Part 3.3 Division 4 of the CYF Act were gazetted by the Minister for Community Services in 2007:

- Standard 2 – support the provision of culturally competent services which are responsive to the needs of children, youth and their families; and
- Standard 3 – staff, carers and volunteers are culturally competent and demonstrate an awareness and appreciation of the needs of Aboriginal and culturally and linguistically diverse children, youth and families.

Finding 8

The Inquiry finds that compliance with Standards 2 and 3 relating to the provision of culturally competent services by community service organisations cannot be assessed reliably because of the lack of data and information on children of culturally and linguistically diverse background within Victoria's system for protecting children.

Child protection and out-of-home care services are also required to follow the *Charter for Children in Out-of-Home-Care*. This charter lists what a child can expect from those people who look after them and work with them when they are in care. It includes the right to be able to take part in family traditions and be able to learn about and be involved with cultural and religious groups that are important to the child or young person. Unfortunately the Inquiry has found that it is not possible to assess the extent to which children and young people in out-of-home care from culturally and linguistically diverse backgrounds are having their cultural and religious needs met.

13.5 Policy context and service provision

Both the Commonwealth Government and the Victorian Government have responsibilities for and deliver services to families and children of culturally and linguistically diverse backgrounds.

13.5.1 Commonwealth Government

Migration policy, refugee resettlement and multiculturalism are the responsibility of the Commonwealth Government, in particular the Department of Immigration and Citizenship (DIAC). It is also worth noting that the Council of Australian Governments' *National Framework for Protecting Australia's Children 2009-2020* is silent on issues relating to children or young people of culturally and linguistically diverse backgrounds.

DIAC is also responsible for providing settlement support to newly arrived refugees and delivers this through the Humanitarian Settlement Services (HSS) program, which provides intensive settlement support to newly arrived humanitarian clients on arrival and throughout their initial settlement period (DIAC 2011b).

Support through the HSS program is tailored to individual needs, including the specific needs of young people. A case management approach oversees and coordinates the delivery of services to clients including airport reception and transit assistance, property induction and initial food provision, assisting clients to register with Centrelink, Medicare, banks, schools and an Adult Migrant English Program provider as well as assistance in relation to health needs. HSS endeavours to strengthen the ability of humanitarian clients to participate in the economic and social life of Australia and to access services beyond the initial settlement period.

An onshore orientation program is also available to all clients aged 15 and over that sets out critical skills and knowledge culturally and linguistically diverse clients need to live and function independently in Australian society.

Exit from the HSS program is based on clients achieving clearly defined settlement outcomes. These include:

- Residing in long-term accommodation (generally a lease of at least six months in duration);
- Being linked to the required services identified in their case management plan;
- School-aged children are enrolled in and attending school; and
- An assessment that clients have understood the messages of the orientation program and hold the skills and knowledge to independently access services.

It is expected these settlement outcomes will generally be reached between six to 12 months of a refugee's arrival.

13.5.2 Victorian Government

In Victoria the development of legislative and policy frameworks, as well as the delivery of services relating to culturally and linguistically diverse communities, is the responsibility of the Victorian Multicultural Commission (VMC), an independent statutory authority. Victorian government departments and agencies that have a role in the broader system for protecting vulnerable children have a range of policy and service approaches in dealing with issues affecting culturally and linguistically diverse communities.

Victorian Multicultural Commission

A key role of the VMC is to ensure a whole-of-government approach to multicultural affairs by ensuring Victoria's culturally and linguistically diverse community needs are represented in public policy and services. It is noteworthy that the Victorian Children's Council, a key advisory body to the Premier and the Minister for Community Services on children, does not have a member with expertise in the issues facing the culturally and linguistically diverse community. Chapter 20 recommends that this is addressed.

The VMC supports sustainable settlement outcomes in local communities for humanitarian entrants to Victoria through the *Refugee Action Plan* (approximately \$1 million per annum). Metropolitan and regional partnerships are developed where refugees settle throughout Victoria under the plan, and funding is provided to key agencies to develop programs to meet local needs. The *Refugee Action Plan* aims to assist refugees to:

- Participate and engage with their new local community;
- Access services including meeting their health needs;
- Identify local issues and concerns;
- Plan tailored, community-owned projects to address issues;
- Improve skills and advocacy for refugees; and
- Enhanced local capacity and improved settlement outcomes.

Examples of *Refugee Action Plan* initiatives focused on parenting and family relationships are given in Table 13.2.

Table 13.2 Relevant *Refugee Action Plan* initiatives

Program	Agency	Communities	Description
Health and wellbeing information sessions	New Hope Foundation	Chin, Karen, Karenni, Burundi, Congolese, Sudanese, Liberian and East African women	Provision of information on health, family safety and wellbeing (with a family relationships component) to enable women to become better informed about the range of mainstream services that they can access for support.
Scienceworks mothers' group	New Hope Foundation	Chin, Karen, Karenni, Burundi, Congolese, Sudanese, Liberian and East African women	Link mothers of preschool-aged children to Scienceworks and provide an opportunity to connect and learn how to play with their children, learning about science together. The program aims to assist mothers: to bond and connect with their kids through play and education; to educate them on the importance of preschool education; and provide strategies that are not language constrained.
Information sessions about Australian services and systems	Ethnic Council of Shepparton and District	Iraqi, Afghani, Sudanese and Congolese	These are provided to improve access and reduce barriers to accessing employment services, the private and public housing system and relating to child protection law within Australia.

Source: Inquiry analysis

Other activities occurring through the *Refugee Action Plan* that aim to build the capacity of families and parents and link them into support services include: men's health and employment programs; women and children's playgroups; social outings for isolated women; Mother's Day celebrations; and other social activities.

The Inquiry notes that refugee settlement is a responsibility of the Commonwealth Government consistent with Australia's international conventions. The Inquiry considers that the adequacy of services for recently arrived humanitarian migrants, particularly with respect to parenting in a new culture and advice about parenting support services, requires further attention. This should be the responsibility of the Commonwealth and state governments. The Inquiry also considers that the needs of children and young people of culturally and linguistically diverse backgrounds should be addressed in the *National Framework for Protecting Australia's Children 2009-2020*.

Recommendation 38

The Victorian Government, through the Council of Australian Governments, should seek inclusion of the needs of recently arrived children and families of culturally and linguistically diverse backgrounds in the *National Framework for Protecting Australia's Children 2009-2020*, in particular:

- The need to provide advice and information about Australian laws and norms regarding the rights and responsibilities of children and parents; and
- Appropriate resettlement services for refugees to prevent abuse and neglect of refugee children.

Department of Human Services

The delivery of culturally appropriate, responsive and equitable services is an expectation across all DHS programs and funded CSOs. DHS' approach includes: a cultural diversity guide; a language services policy and interpreting services; the provision of a refugee program; support for family violence services for immigrant women; and specific placement practices discussed below.

Cultural Diversity Guide

DHS has developed the *Cultural Diversity Guide* (DHS 2006a) to assist programs and CSOs by:

- Supporting the human services system to meet obligations under whole-of-government reporting on responsiveness to cultural diversity;
- Identifying a range of strategies to improve cultural responsiveness and levers to effect cultural change;
- Illustrating the different strategies and levels with examples of good multicultural practice that are already in place; and
- Providing guidance on additional resources and supports for programs and agencies in managing diversity.

The *Cultural Diversity Guide* provides key strategies and best practice including:

- Understanding culturally and linguistically diverse clients and their needs;
- Building better partnerships with multicultural and ethno-specific agencies;
- A more responsive culturally diverse workforce;
- Using language services to best effect; and
- Encouraging participation and decision making with members of culturally and linguistically diverse communities.

Language Services Policy

DHS' *Language Services Policy* (DHS 2005) outlines the requirements necessary to enable people with low English proficiency to access professional interpreting and translating services when making significant life decisions and where essential information is being communicated. The three minimum language requirements of the policy are:

- Clients who are not able to communicate through written or spoken English have access to information in their preferred language;
- Language services are provided by appropriately qualified staff accredited by the National Accreditation Authority for Translators and Interpreters Inc.; and
- People, including family members under the age of 18, are not used as interpreters.

Interpreting services

Organisations that receive funding from DHS' Children, Youth and Families Division are eligible to access interpreters. Annual funding of approximately \$90,000 provides interpreter services for program-specific needs for DHS funded agencies in:

- Family services;
- Sexual assault and family violence services;
- Family intervention services;
- Youth services and youth justice; and
- Placement and support services.

DHS child protection practitioners, on the other hand, can access interpreter services on a fee-for-service basis for which no dedicated funds are provided.

Information provided by DHS to the Inquiry indicates that the allocated budget does not meet demand and is exhausted quickly each month.

Refugee Minor Program

In addition, DHS has coordinated government departments to provide the Refugee Minor Program, which delivers a statewide service to support the settlement process of unaccompanied humanitarian minors and ensures they receive care arrangements. An unaccompanied humanitarian minor is defined as being under 18 years old, unaccompanied by their parents, holding a refugee or humanitarian visa and referred by DIAC. Referrals to the program come from DIAC, after the unaccompanied humanitarian minors have been assessed and granted a permanent visa. The Refugee Minor Program is jointly funded by the Commonwealth and Victorian Government at a total of \$5 million per annum.

Unaccompanied humanitarian minors who arrive in Australia and do not have a close adult relative aged over 21 years are classified as wards of the Commonwealth Minister for Immigration. The Victorian Minister for Community Services has the delegated guardianship responsibility for all unaccompanied humanitarian minors living in Victoria designated as wards by the Commonwealth. To this extent, there is a joint responsibility of care for these young people.

The Refugee Minor Program provides support to highly vulnerable humanitarian minors from disadvantaged culturally and linguistically diverse backgrounds to transition into Australian cultural norms. The program provides direct services to clients to assist them (and their relatives or carers) to develop key settlement competencies while also establishing and maintaining partnerships with other key agencies in the community. Clients can be given assistance on a variety of issues ranging from accommodation and financial support to physical and emotional health needs, cultural and religious continuity, education, social and recreational needs and developing or maintaining client/family connectedness. According to data provided by DHS, the Refugee Minor Program currently assists 380 clients, of whom 218 are aged 15 to 18 years old.

Family violence services

Despite the lack of specific statistics on the prevalence of family violence in migrant families, it is known that being newly settled does expose families to stresses that increase the risk of intimate partner violence. Women from immigrant and refugee backgrounds face greater obstacles when attempting to escape family violence. These obstacles compromise their safety and wellbeing.

In 2010-11 DHS provided \$874,000 to the Domestic Violence Resource Centre to provide a range of family violence services in Victoria. One of these services is the Immigrant Women's Domestic Violence Service (IWDVS), which provides:

- Joint case management with relevant family violence services and other relevant services in Victoria to support women and children experiencing family violence;
- Information, support and referral for women in crisis; and
- Secondary consultations to service providers.

The IWDVS brokers services in the family violence service system and works in conjunction with these services to provide support to the clients.

Placement practice

When DHS is undertaking a placement referral, there is a practice standard to encourage the identification of a child or young person's ethnicity, culture and religion. The matching process is informed by the information contained in the placement referral. The *Looking After Children – Care and Placement Plan* is intended to identify the child or young person's needs and describes how these needs will be met. Under this plan, carers and residential workers should be informed about how these children and young people will participate and sustain cultural and community events relevant to their background and observe and practice religious beliefs and activities.

However, feedback to the Inquiry indicates poor adherence to these practices. Children and young people are placed with families from different cultural and religious backgrounds, often without a cultural plan or advice about meeting a child's cultural and religious needs to assist the carers. Ms M, a respite and emergency foster carer, advised the Inquiry of a young Muslim boy who came into her care from a small country town. The boy was previously placed with a carer who struggled with his behaviour. It became apparent that the difficulties in caring for the child were related to cultural and religious differences and it was only after Ms M, by chance, was able to connect the child with an elder of the same cultural background that the placement ran smoothly (Ms M, Shepparton Public Sitting). This example highlights the need for care arrangements to address the cultural identity of children and young people, and for appropriate support to be given to carers and children.

Similarly, Mr Assafiri advised the Inquiry about the difficulties young Muslim children face when they are placed into non-Muslim foster care. Mr Assafiri outlined the cultural barriers he faced growing up as a young Muslim child in foster care from the age of six. Mr Assafiri explained that he grew up without a sense of identity and that this had lasting effects on his ability to finish his education, develop meaningful relationships and find a place to live that he called home.

Although everybody's life is different, the one thing I have learned is the importance of establishing a connection with either an individual or a small community (Mr Assafiri, Broadmeadows Public Sitting).

Mr Assafiri suggested greater early intervention support with culturally and linguistically diverse families to assist them with life's challenges to find harmony between two competing cultures – the Middle Eastern and Western culture. Building supports for culturally and linguistically diverse families will not only benefit the parents and the children but the community as a whole by building resilience and respect (Mr Assafiri, Broadmeadows Public Sitting).

Department of Health

The Department of Health (DOH) provides a number of programs to provide general health and mental health services to refugees and their families. The Refugee Health Nurse Program (\$1.8 million per annum) provides a response to the poor and complex health issues of arriving refugees. It aims to:

- Increase refugees' access to primary health services;
- Improve the response of health services to refugees' needs; and
- Enable refugee communities to improve their health and wellbeing.

The refugee health nurse is based in community health services and employs community health nurses, with expertise in working with culturally and linguistically diverse and marginalised communities to provide a coordinated health response to newly arrived refugees, including children and young people. The program:

- Operates in areas with high numbers of newly arrived refugees;
- Supports a coordinated model of care, and acknowledges the importance of early identification and intervention in health issues in the early stages of settlement; and
- Aims to improve the health of refugees through: disease management and prevention; the development of referral networks and collaborative relationships with general practitioners and other health providers; connection with social support; and orientation programs.

The Migrant Mental Health Taskforce is a joint venture between the Victorian Mental Health Reform Council and the VMC. It is a statewide program that improves access and responsiveness to mental health services for culturally and linguistically diverse communities. It includes the development of migrant community ambassadors to build culturally connected responses to mental health services, and to better coordinate funding and organisational activities by streamlining multicultural mental health services organisations.

DOH provides approximately \$345,000 per annum to the Victorian Foundation for Survivors of Torture (Foundation House) to deliver a range of mental health and support services to people from refugee backgrounds who have survived torture or war-related trauma. Foundation House provides direct services to clients in the form of counselling, advocacy, family support, group work, psycho-education, information sessions and complementary therapies. Direct services to clients are coupled with referral, training and education roles aimed at developing and strengthening the resources of various communities and service providers.

Foundation House also:

- Offers training and consultancy to other service providers who have contact with survivors of torture and trauma;
- Develops resources to enhance the understanding of the needs of survivors among health and welfare professionals, government and the wider community;
- Works with government, community groups and other providers to develop services and programs to meet the needs of survivors;
- Works with the Commonwealth and state governments to ensure relevant policies are sensitive to the needs of survivors;
- Works with international organisations towards the elimination of torture and trauma; and
- Conducts and contributes to research through a partnership with La Trobe University's Refugee Health Research Centre.

Foundation House's primary locations are in Brunswick and Dandenong and a number of services are provided on an outreach basis across Melbourne and in regional areas of Victoria.

DOH also has also established the Victorian Transcultural Psychiatry Unit to enhance training, support and to assist with language and cultural barriers that present obstacles for culturally and linguistically diverse communities when accessing appropriate mental health treatment and care.

The Inquiry has been unable to ascertain the extent to which these services address risk factors that may impact on the involvement of children and young people of culturally and linguistically diverse backgrounds in the time available to the Inquiry.

Department of Education and Early Childhood Development

In 2010-11 approximately 3,400 school-aged children and young people of culturally and linguistically diverse backgrounds emigrated to Victoria, of whom approximately 900 were refugees (DIAC 2011a).

The Department of Education and Early Childhood Development's (DEECD) multicultural strategy, *Education for Global and Multicultural Citizenship*, has a number of objectives including:

- Improving educational outcomes for all students relevant to global and multicultural citizenship;
- Developing the intercultural literacies that students, parents, educators and leadership groups need;

- Enhancing the engagement, wellbeing and sense of belonging for all students; and
- Building and sustaining school-community partnerships that prepare all students for global and multicultural citizenship (DEECD 2009a).

An example of this strategy in practice includes strengthened consultation with established culturally and linguistically diverse community groups to promote parental participation in schools and early childhood programs.

DEECD provides additional support to refugee students with disrupted schooling to improve educational outcomes and build the capacity of schools to meet the extra needs of these students. Multicultural education aides bridge the gap in knowledge and understanding between students and teachers, and between school and families. By working one-on-one, aides help students understand school and develop their learning and social skills. Refugee students also qualify for the Education Maintenance Allowance, a payment provided to families on a low income to support their child's education up to the age of 16.

DEECD also provides a range of maternal and child health (MCH) services to engage and sustain services to culturally and linguistically diverse communities that include the following:

- Additional home visits to mothers from culturally and linguistically diverse communities where there is a traditional 'lying in' period where both mother and baby have to stay at home for 40 days;
- Professional interpreters to enable accurate transfer of information and assistance to culturally and linguistically diverse clients;
- Cultural playgroups and women's groups to enhance parenting and family functioning, encourage families to attend MCH visits;
- Active recruitment of bi-lingual MCH nurses and supported playgroup facilitators;
- Translated health promotion materials to families;
- Assisting culturally and linguistically diverse clients to access other services such as Births Deaths and Marriages, Centrelink, housing services and child care; and
- Cultural competence training (provided in 2010-11 to 450 MCH nurses).

There is a vast array of programs across government agencies that promote and address the needs of culturally and linguistically diverse communities in Victoria – some involve engagement with the Commonwealth. However, many of these programs are unrelated. In the absence of data about the number of culturally and linguistically diverse communities involved and accessing parenting support services or responding to abuse and neglect, it is hard to draw conclusions on the effectiveness of these programs.

13.6 Culturally competent service provision

Meeting the needs of a diverse culturally and linguistically diverse population is a challenge for governments in Australia. Developing the cultural competence of the workforce and recognising the importance of values, beliefs and culture, as well as the background of different communities will result in improved service provision (see Chapter 12 for a definition of cultural competence). To effectively meet the needs of all children and young people, services must recognise cultural differences and, where appropriate, provide culturally competent support.

From an operational perspective, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in suitable cultural settings, increasing the quality of services and producing better outcomes (Davis 1997).

Little is known about the extent to which families of culturally and linguistically diverse backgrounds access family services compared with other families, or whether the kind of service they receive meets their needs effectively. International literature points to three key barriers that ethnic minority families may experience (Sawrikar & Katz 2008, p. 6):

- Cultural barriers – includes language barriers, cultural norms that prohibit seeking extra-familial support, traditional gender roles that prevent men from engaging with services or discussing family difficulties, and fear of authorities;
- Structural barriers – includes practical barriers accessing services and lack of knowledge or understanding of available services; and
- Service-related barriers – a service is considered culturally inappropriate or is not perceived as relevant due to lack of cultural diversity in the workforce or there is a concern that they will not be understood or will be stereotyped or judged.

It is difficult for some families of culturally and linguistically diverse backgrounds to understand the role of family services agencies and child protection, particularly for those with a fear of authority and a lack of understanding of family services and child protection processes. This fear can mean that many parents are scared that their children will be taken away (The Victorian Foundation for Survivors of Torture Inc & Horn of Africa Communities Network Inc. 2007, pp. 23, 43-47). A lack of cultural awareness by workers around traditional childrearing practices was highlighted as an issue for refugee families settling in Australia (Lewig et al. 2009). Moreover, culturally and linguistically diverse families fear that case workers misunderstand or disrespect their cultural needs (Sawrikar 2009).

Addressing the needs of African families at a Melbourne Public Sitting, Mr Smith highlighted that greater communication with African communities was required to promote better understanding the Australian cultural norms and to prevent the need for DHS to become involved with these families (Mr Smith, Melbourne Public Sitting).

A major finding of the South Australian study was the 'critical significance of culturally competent child protection practice when working with refugee families' (Lewig et al. 2009). The researchers made recommendations for working appropriately with refugee families:

- Families needed support to build stronger relationships between parents and their children, including enhancing communication skills within the family, as well as stronger collaboration with parents and their children's schools;
- Parents also needed additional information on parenting practices in Australia and child protection laws; and
- Parents needed culturally appropriate information about services and supports available to assist them in their parenting roles.

Community participants in the research emphasised the importance of engaging collaboratively with communities in the development of interventions to support refugee families, especially encouraging the involvement of older community members and providing places for communities to gather socially.

Implications for child protection practice identified by Sawrikar (2009) include:

- Effective education and training in cultural competency will help case workers provide effective treatment for the culturally and linguistically diverse family, rather than attributing responsibility and blame to the family for the occurrence of the abuse or neglect to a culturally and linguistically diverse child;
- Individual relationships with the case worker and the culturally and linguistically diverse family is the most crucial aspect of culturally appropriate service delivery and systemic organisation change is required to ensure all culturally and linguistically diverse families that enter the child protection system can be provided this benefit; and
- Case workers should consider the appropriateness of case-matching when selecting an interpreter.

In Chapter 16, the Inquiry investigates the need for improving the level of cultural competence of integrated family services and statutory child protection services. A culturally competent workforce in this regard includes a better understanding of culturally and linguistically diverse communities through better education and training.

13.6.1 Themes arising from submissions

Feedback through the Inquiry's Public Sitings and written submission process on issues related to culturally and linguistically diverse communities and their interaction with child protection was surprisingly limited, given that culturally and linguistically diverse families are significantly represented in our general population. This Inquiry believes this is a result of a number of factors including the cultural barriers identified by Sawrikar (2009), as referred to earlier in this chapter:

The challenge for culturally and linguistically diverse communities is their ability to navigate the child protection system and being able to identify their needs to policymakers for increased and improvement in service provision (Mr Kaur, Melbourne Public Sitting).

Nonetheless the Inquiry was informed by a number of verbal submissions, written submissions and by the consultation with community workers arranged by the Ethnic Communities Council of Victoria. Three key themes arose:

- The need for improved focus of prevention and early intervention services;
- Whether services should be delivered through mainstream agencies or targeted and;
- Culturally appropriate service provision.

Prevention and early intervention

Improved prevention and early intervention strategies focusing on culturally and linguistically diverse families were raised in a number of submissions. Children and families from culturally and linguistically diverse backgrounds are at high risk and yet there are very few preventative or early interventions designed to ensure they do not become involved with the tertiary end of the service system. Working with culturally and linguistically diverse communities requires outreach and community development. Community education and information is required to ensure culturally and linguistically diverse communities, particularly new arrivals from migrant and refugee communities, understand how child protection works in Australia, and what their rights and responsibilities are (Windermere Child and Family Services submission, p. 13).

The Victorian Council of Social Services (VCOSS) argued that while culturally and linguistically diverse families may attend initial MCH appointments, many of these families do not re-engage with universal services again until school, which means they may miss out on many early intervention and prevention supports. More assertive outreach services are required to ensure services more effectively reach out to these families (VCOSS submission, p. 28).

During a visit to the City of Hume MCH services clinic at Broadmeadows, the Inquiry was informed about the important role MCH nurses play in identifying and responding to vulnerable children and their families in need. On average more than 2,000 families in the City of Hume use the universal MCH service, with 99 per cent take up by mothers in the first year of their child's life. The Inquiry was advised that for many culturally and linguistically diverse families, in particular for those of a traditional Muslim background, this may be the only universal services being accessed and bringing isolated women outside their homes.

Mainstream or dedicated services

The Royal Children's Hospital (RCH) argued that all groups (including culturally and linguistically diverse) should have access to services that meet their individual needs in mainstream services to avoid these groups from being marginalised. Increased training in these universal services on cultural awareness is seen as more appropriate than a separate service (RCH submission, p. 3).

However, the Social Work Department of the RCH and Wadja Aboriginal Family Place submission (p. 3) argued that the child protection system is founded on Western, Anglo-Saxon values, policies and staffing. It strongly recommended that services for culturally and linguistically diverse families be enhanced.

VCOSS argued that there is a clear need for dedicated support to assist families to understand expectations about child-rearing practices and that this information cannot just be in written form as this will not target harder to reach communities (VCOSS submission, p. 28). VCOSS also called for resources to ensure ongoing cultural competence training for staff in universal services to ensure these services are better placed to work with these families.

Culturally appropriate service provision

A consistent theme raised in submissions concerned the variation in practice by DHS when dealing with families of Aboriginal or Torres Strait Islander background and of culturally and linguistically diverse background. In a verbal submission to the Inquiry, Ms Katar outlined that different placement processes apply when removing Aboriginal and culturally and linguistically diverse children from their homes. If an Aboriginal child is removed from their family, the order of placement is: first, the child's extended family; second, the child's indigenous community; and third, other Indigenous people. Only if an appropriate placement cannot be found within these three groups will the child be placed with a non-Indigenous carer. The same principles should apply to children from a culturally and linguistically diverse background (Ms Katar, Dandenong Public Sitting).

Imam Bardi advised the Inquiry that in Australia there are refugees from Sudan, Iraq, Kuwait, Bosnia and Kosovar, and stated that authorities have not recruited culturally diverse carers who would have a better understanding of the cultural competence in these communities (Imam Bardi, Shepparton Public Sitting).

The importance of children and young people of culturally and linguistically diverse backgrounds being connected with their culture and religion when placed in community care was outlined by Mr Taha, representing the Islamic Council of Victoria at the Melbourne Public Sitting, drawing on his work with troubled ethnic youth in prisons and detention centres (Mr Taha, Melbourne Public Sitting).

Care with Me, an organisation with the aim of engaging and supporting culturally and religiously diverse Muslim families by securing Muslim foster carers, organised written submissions and oral presentations by a range of speakers at numerous Public Sittings throughout Victoria. These submissions outlined the various needs of culturally and linguistically diverse communities in Australia, and highlighted the need for increased funding, training and specialised services. Care with Me made the following recommendations:

- Increased government funding for ethnic-specific family services and better out-of-home care support for culturally and linguistically diverse families;
- Support for ethnic CSOs to implement best practice cultural practices and matching for children and young people in out-of-home care;
- Improved standards of accreditation of DHS case workers that includes ongoing cultural training and a knowledge base to engage ethnic organisations for advice and assistance meeting specific cultural needs; and
- An evaluation of current cultural practices, record keeping and statistical reporting within DHS (Care with Me submission, p. 7).

The RCH and Wadja Aboriginal Family Place submission (p. 3) called for tertiary education places for students from culturally and linguistically diverse backgrounds to develop the capacity of the child protection and family services systems to meet the needs of culturally and linguistically diverse families. The submission suggests that DHS considers the appointment of cultural advisers from key culturally and linguistically diverse communities to better inform the department of cultural differences and norms. They also recommend that access to interpreters be improved through increased funding for interpreting services, arguing that, at present, there are situations where interpreters are not available or utilised thereby increasing the vulnerability and powerlessness of families entering Victoria's system for protecting children.

DHS has provided practice advice to practitioners about working with families of culturally and linguistically diverse communities. If the child has a particular cultural identity, a member of the appropriate cultural community who is chosen or agreed to by the child or by his or her parent should be permitted to attend meetings held as part of the decision making process. The Inquiry is unable to make a judgment on the use of this practice advice due to an absence of data related to the degree of compliance by statutory child protection staff.

13.6.2 Consultation with culturally and linguistically diverse community workers

In 2010 the Ethnic Communities' Council of Victoria (ECCV), the peak advocacy body representing ethnic and multicultural communities, was advised that newly arrived communities had become fearful of statutory child protection intervention and removal of children. After concerns had been discussed with culturally and linguistically diverse community members and workers in relation to vulnerable families and child protection practices, ECCV convened a roundtable between the workers and DHS in September 2010.

A summary paper prepared for the September 2010 roundtable with DHS contained recommendations in relation to:

- Developing culturally responsive practice for working with families from newly arrived refugee communities;
- Developing effective language strategies when working with families and children from newly arrived refugee communities;
- Strengthening the services offered to unaccompanied minors;
- Building the capacity of family services to appropriately manage the support needs of newly arrived refugee families;
- Improving methods of addressing family violence and sexual assault in newly arrived refugee communities; and
- Improving data collection across DHS' Children, Youth and Families Division to include the collection of refugee status, country of birth and preferred language.

It is understood that the change of government after the State election in November 2010, and the commencement of this Inquiry has placed these issues temporarily on hold.

The Inquiry notes that the ECCV's roundtable recommendations are supported by the Inquiry's own consultations and recommendations. A timetable for implementation of the Inquiry recommendations is contained in Chapter 22. The Inquiry has not, however, addressed all these recommendations in detail.

Matter for attention 8

The Inquiry draws the Government's attention to the need to continue discussions with groups such as the Ethnic Community Council of Victoria's community workers concerning the need to ensure services to protect children from abuse and neglect meet the needs of the culturally and linguistically diverse communities and are delivered in a culturally competent manner.

The Inquiry sought advice from the ECCV about how to best consult with communities on issues affecting culturally and linguistically diverse communities. As a result, the ECCV assisted the Inquiry to convene a consultation with culturally and linguistically diverse community and settlement workers and other representatives of newly arrived communities with experience working with vulnerable families engaging with child protection and related services.

The Inquiry's consultation with culturally and linguistically diverse workers was held in August 2011 and was attended by 12 community workers. The workers' comments reinforced earlier advice to the Inquiry about a lack of uniform DHS data on the ethnicity of clients. Further, they felt there was no systemic utilisation of cultural knowledge or systematic way to help a family that may have different cultural needs. The workers reported that there is a need for better support to culturally and linguistically diverse families to keep their children at home through culturally appropriate programs and, if placements are required, these should be made within their own cultural community. It was felt that child protection staff lack training in cultural issues and do not adequately engage culturally and linguistically diverse agencies.

The community workers reported that the Family and Reproductive Rights Education Program, a program funded by DHS to work with women from cultures in which female circumcision has traditionally been practised, is not integrated with child protection practice and there is little collaboration. A community worker provided an example of trying to work collaboratively with DHS to organise a meeting for families where female circumcision is an issue so that DHS could educate the community about its role. The child protection practitioners agreed to attend in business hours when families were unavailable due to work commitments.

13.6.3 Summary of consultation input

In summary, feedback from the Inquiry's consultation process about improvements to the system is that there is a need:

- To assist children and young people of culturally and linguistically diverse backgrounds to thrive and develop in their families, and local culture, while maintaining their place in their community, through providing support and education to vulnerable culturally and linguistically diverse families;
- To develop culturally appropriate community education programs that include a focus on positive parenting skills and family strengths for culturally and linguistically diverse families;
- For a community-wide acknowledgement that newly arrived culturally and linguistically diverse families are vulnerable when they first arrive in Australia and that culturally responsive services are required to manage their transition;
- For additional resources to fund support for culturally competent education and therapeutic programs to assist culturally and linguistically diverse families;
- To improve the collection of data and recording of information (ethnicity, culture and religion) by DHS and other government departments related to the prevalence of child abuse within culturally and linguistically diverse communities;
- For a culturally competent child protection intervention model using the Indigenous model that focuses on family and friendship connections as a starting point;
- For collaborative partnerships between statutory child protection and culturally and linguistically diverse community agencies;
- To attract more carers from culturally and linguistically diverse backgrounds to provide better placements for children of culturally and linguistically diverse backgrounds;
- For more appropriate use and availability of interpreters within the system for protecting children and young people;
- To improve cultural competence of child protection workers through better training and education; and
- The importance of capturing the history of the child or young person while in care.

13.7 Conclusion

The evidence before the Inquiry suggests there are particular problems confronting some families of culturally and linguistically diverse backgrounds in settling into a new culture. With social norms in Australia about parenting and the rights of children often being different from their homeland, some families of culturally and linguistically diverse background may become involved with statutory child protection services. However, the absence of data makes analysis of the extent of the problem impossible.

As some children (and their families) from culturally and linguistically diverse communities will find themselves within the statutory child protection system, workforces and programs engaging these families will need to meet the cultural and religious needs of children in a respectful and accommodating way.

Service provision must become more culturally appropriate and the workforce more culturally competent. The issue of cultural competence of the workforce is addressed further in Chapter 16.