Report of the **Protecting** Victoria's Vulnerable **Children** Inquiry
Volume 3

January 2012

The Honourable Philip Cummins (Chair)
Emeritus Professor Dorothy Scott OAM
Mr Bill Scales AO

State Government Victoria

Published by the Department of Premier and Cabinet,
1 Treasury Place, Melbourne, Victoria, Australia January 2012

ISBN 978-1-921831-96-6
ISBN 978-1-921831-94-2

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Ordered to be printed
Victorian government printer
February 2012
Session 2010–2012
P.P.No. 112

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Appendices

Appendix 1:
Protecting Victoria's Vulnerable Children Inquiry Panel Members

The Honourable Philip Cummins (Chair)

The Chair of the Inquiry is the Honourable Philip Cummins, a former Victorian Supreme Court Judge, who has had a long commitment to child protection. In 1993 he was the judge in the Supreme Court trial for the murder of Daniel Valerio, which was a catalyst for the introduction in Victoria of mandatory reporting of child abuse, which he recommended. Upon his retirement from judicial office in November 2009, Mr Cummins became Co-Patron of Child Abuse Prevention Research Australia (CAPRA), and also undertook research in the Faculty of Medicine at Monash University into child abuse, with a particular focus on children's experiences of the court process. Upon his appointment as Chair of the Inquiry, he relinquished both these positions. Mr Cummins was a Queen's Counsel in Victoria, New South Wales and the ACT for 10 years prior to his appointment to the Bench. He was Chairman of the Victorian Bar and Senior Vice-President of the Australian Bar. He was a Judge of the Supreme Court of Victoria from 1988 to 2009, sitting in all its Divisions and in the Court of Appeal. He was Senior Judge of the Trial Division of the Court and Principal Judge of the Criminal Division. He holds degrees of Master of Laws and Master of Science (Psychiatry) from The University of Melbourne and is a Senior Fellow (Hon) in the Law School at that University.

Emeritus Professor Dorothy Scott OAM

Emeritus Professor Dorothy Scott, the Acting Director of the Australian Centre for Child Protection since December 2011, was the Foundation Chair of Child Protection and the inaugural Director of the Australian Centre for Child Protection at the University of South Australia until she retired in 2010. She has worked in the fields of mental health and child protection and developed the first sexual assault counselling service in Victoria in the 1970s. Professor Scott has conducted several child protection inquiries and been an adviser to State and Commonwealth Governments. For her service to the community Professor Scott was awarded the Medal of the Order of Australia and the Centenary Medal. The author of five books and many refereed articles, Professor Scott has been influential nationally and internationally in improving approaches to preventing and responding to child abuse and neglect.

Mr Bill Scales AO

Mr Scales brings a broad range of experience from business, government, public policy and the community to the Inquiry Panel. In addition to his role on the Panel, he currently holds the positions of Chancellor at Swinburne University of Technology, a Panel Member of the Australian Government Review of Funding for Schooling, a member of the Advisory Board of Veolia Australia, and a Victorian Council Member and a Member of the National Education Advisory Committee of the Australian Institute of Company Directors. Mr Scales has also held positions as Chair of the Port of Melbourne Corporation; Secretary, Department of Premier and Cabinet in Victoria; Group Managing Director, Regulatory, Corporate and Human Relations and Chief of Staff, Telstra Corporation; Chair and CEO of the Industry/ Productivity Commission; Chair of the Australian Government's Safety and Compensation Council and Commissioner of the Australian Government's Safety Rehabilitation and Compensation Commission; Chair and CEO of the Automotive Industry Authority; Administrator of the City of Brimbank; Panel Member of the Review of Australian Higher Education and a Member of the Expert Reference Group to advise the Australian Government on regulatory matters related to the Higher Education Sector; and chair and member of many other boards, councils and committees.

Appendix 2: Inquiry submissions, Public Sittings and consultations

1. Explanatory note on publication of submissions

Committed to an open and transparent process, the Inquiry has sought to publish every written submission that it has received on its website. The Inquiry has also published transcripts of verbal submissions made at Public Sittings and outcomes from Reference Group meetings. The Inquiry's Guide to Making Submissions, released in February 2011 provided advice on making submissions. General guidance notes were also published on the website and were provided to people before they made statements at Public Sittings.

The Inquiry received a number of submissions where confidentiality was requested by the author. These submissions were not automatically withheld from publication. Where the reasons for requesting confidentiality were not clear, the Inquiry consulted with the authors of the submission to identify the reasons for their request. Twenty one submissions were not published where the Inquiry was satisfied that there were sufficient grounds for confidentiality and the submission could not be altered to allow partial publication. These submissions have not been cited in the Report.

Publication of other submissions had the potential to raise significant legal risks, both for the author and the Inquiry. These risks arose because the Inquiry was not Court of law, or established with Royal Commission or Parliamentary Inquiry powers and therefore could not grant privileges protecting individuals from subsequent liability. These submissions were either withheld from publication or were published in a manner that minimised that risk for example, by blanking out, or redacting, parts of the text. Some individual speakers at public sittings were represented in the transcript using initials rather than disclosing their full identities, particularly where the content of their statements could potentially have led to the identification of children or young people or parties to court proceedings or orders. Areas of legal risk relating to both written submissions and the transcripts of verbal submissions, involved text that:

- Named or included other personal identifier references in relation to children who are potentially the subject of a child protection order or currently involved in a proceeding in the Children's Court contrary to the Children Youth and Families Act 2005;
- Named individuals potentially the subject of an investigation under other legislation (such as the Ombudsman Act 1973 or the Whistleblowers Protection Act 2001);
- Named individuals contrary to a court suppression order;
- Were, in effect, a report of a child in need of protection under the Children Youth and Families Act 2005;
- Provided personal information (such as date of birth, address, telephone, email, social networking account details) about individuals;
- Identified individual public servants and their comments on the administration of a government department, potentially in contravention of section 95 of the Victorian Constitution Act 1975; and
- Made potentially defamatory comments.

2. List of submissions received

Aboriginal Family Violence Prevention and Legal Service Victoria

Anderson, Katharine

Anex

Anglicare Victoria

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

Association for Children with a Disability

The Australian Centre for Social Innovation

Australian Childhood Foundation

Australian Nursing Federation (Victorian Branch)

Australian Services Union

Baptcare

Barron, Dan

Barwon Centre Against Sexual Assault

Bass Coast Regional Health

Bendigo Community Health Services

Berry Street

Bessant, Judith (Professor) and Emslie, Michael, RMIT University

Bethany Community Support and Glastonbury Child & Family Services

beyondblue

Blake, Pauline

Bonnes, Margaret

Bravehearts Inc

Braybrook, Vicki

Brydon, Kerry (Dr), Department of Social Work, Monash University

Burchell, Bernadette

Burgen, Brenda

Caird, Sherrin

Care Leavers Australia Network

Care with Me Inc

Caroline Chisholm Society

Catholic Archdiocese of Melbourne

Catholic Bishops of Victoria

CatholicCare

Centre Against Sexual Assault Forum

Centre for Excellence in Child and Family Welfare Inc

Chatley, Bernie

Cherrie, Brian

Child & Family Services Ballarat Inc

Child Wise Ltd

Children's Protection Society

Children's Court of Victoria no. 1

Children's Court of Victoria no. 2

City of Greater Bendigo

City of Greater Dandenong, Family and Children's Services

Community and Public Sector Union

Community Child Care Association Inc

Community Connections (Vic) Ltd

Connections UnitingCare

Connolly, Marie (Professor), Department of Social Work, The University of Melbourne

Cooper OAM, Barrie R

CREATE Foundation

Curtis, Katy

D'Costa, Geraldine

Disability Services Commissioner Victoria

Domestic Violence Victoria

Donnellan, Luke (MP), Shadow Minister for Child Safety

Drummond Street Services

EACH Ltd, Primary Care Child and Family Services

Early Childhood Intervention Australia - Victorian Chapter

East Gippsland Discussion Group

Eastern Region Family Violence Partnership

Edyvane, Georgia

Family Alcohol and Drug Network

Family Life

FamilyCare

Fanning, David

Featherston, Lyn

Federation of Community Legal Centres (Victoria) Inc

Felton, Philip

Ferguson, Rhonda

Foster Care Association of Victoria Inc

Foster Care Association of Victoria Inc (supplementary submission)

Fox, Karen and other kinship carers

Frederico, Margarita (Associate Professor), the School of Social Work and Social Policy and the Bouverie Centre, La Trobe University, The University

of Melbourne, Take Two Berry Street Victoria and the Victorian Aboriginal Child Care Agency

Gaffney, Jill

Gall, John AM (Dr)

Gardiner, Simon

Gavaghan, John

Gippsland Centre Against Sexual Assault

Goddard, Chris (Professor), Mudaly, Neerosh (Dr) and Frederick, John (Dr), Child Abuse Prevention Research Australia, Monash University

Good Beginnings Australia

Good Shepherd Youth & Family Service

GordonCare

Grandparent Group

Grandparents Victoria Inc and Kinship Carers Victoria

Grantham, Geoffrey

Haddock, Ken

Harmer, Sue

Holmesglen, Department of Social Science

Hughes, Lynette M

Human Evolvement Logical Progress Pty Ltd

Humphreys, Cathy (Professor), Department of Social Work, The University of Melbourne - (a) Children Affected By Family Violence

Humphreys, Cathy (Professor) and Campbell, Lynda (Dr), Department of Social Work, The University of Melbourne - (a) A Stressed Child Protection Service

Humphreys, Cathy (Professor) and Campbell, Lynda (Dr), Department of Social Work, The University of Melbourne - (b) Protecting Children Through The Children's Court

Humphreys, Cathy (Professor) and Campbell, Lynda (Dr), Department of Social Work, The University of Melbourne - (c) The Role & Functioning of Family Services

Humphreys, Cathy (Professor) and Kiraly, Meredith, Department of Social Work, The University of Melbourne – (a) Aboriginal Children In Kinship Care

Humphreys, Cathy (Professor) and Kiraly, Meredith, Department of Social Work, The University of Melbourne - (b) Kinship Care

Humphreys, Cathy (Professor), Campbell, Lynda (Dr) and Tsantefski, Menka (Dr), Department of Social Work, The University of Melbourne – (a) Children Exposed To Parental Alcohol & Drug Misuse

Humphreys, Cathy (Professor), Kertesz, Margaret (Dr) and The Who Am I? Academic Team, Department of Social Work, The University of Melbourne – (b) Identity, Record Keeping & Children In Care

Humphreys, Cathy (Professor), Tokatlian, Nicole et al. Department of Social Work, The University of Melbourne

Independent Pastoral Care

ISIS Primary Care

Jesuit Social Services

Johns, Ronda

Joint SCO submission – see 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

Jordan, Brigid (Associate Professor)

Kildonan UnitingCare

La Roche, Philip R

Law Institute of Victoria

Life Without Barriers

Lighthouse Foundation

Lockwood-Penney, Andrew

MacKillop Family Services

Mallee Accommodation and Support Program

Mallee Family Care

Matthews, Ben (Associate Professor, Dr), Faculty of Law, Queensland University of Technology

McCallum, Valma

Melton Shire Council

Mendes, Philip (Associate Professor), Department of Social Work, Monash University

Mercy Health O'Connell Family Centre, The Queen Elizabeth Centre and Tweddle Child and Family Health Service

Mercy Health O'Connell Family Centre

Mercy Hospital for Women

Merri Community Health Services

Miles, Russell

Mitchell, Gaye (Dr) and Campbell, Lynda (Dr), Department of Social Work, The University of Melbourne - The Need For A New Approach To Excluded Families

MonashLink Community Health Service Limited

Monie, Christopher

Moonee Valley City Council

Mungabareena Aboriginal Corporation (supplementary submission)

Municipal Association of Victoria

Narbett, Daniel

National Council of Women of Victoria Inc

North East Metro Child and Family Services Alliance

North West Welfare Alliance

North Western Metro Indigenous Regional Action Group

Northern Centre Against Sexual Assault

O'Callaghan QC, Peter, Independent Commissioner, Catholic Archdiocese of Melbourne no. 1

O'Callaghan QC, Peter, Independent Commissioner, Catholic Archdiocese of Melbourne no. 2

Obradovic, Anjelka

Odyssey House Victoria

Office of the Child Safety Commissioner

Office of the Public Advocate

Open Place

Owen, Lloyd

OzChild

Parenting Research Centre

Perry, Elizabeth

Perversi, Paul

Playgroup Victoria

Post Placement Support Service (Vic) Inc

Powell, Martine (Professor), Deakin University and Snow, Pamela (Associate Professor), Monash University

Queen Elizabeth Centre

Respite Care Project Consortium

The Royal Australasian College of Physicians

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

The Royal Australian College of General Practitioners Victoria Faculty

The Royal Children's Hospital, Paediatric Intensive Care Unit

The Royal Children's Hospital

The Royal Children's Hospital Integrated Mental Health Program, Addressing Family Violence Programs

The Royal Children's Hospital, Centre for Adolescent Health

The Royal Children's Hospital, Social Work Department and Wadja Aboriginal Family Place

The Royal Women's Hospital

Salesians of Don Bosco

The Salvation Army

Sheehan, Rosemary (Associate Professor), Department of Social Work, Monash University

Smith, Angela

South Western Centre Against Sexual Assault

St Luke's Anglicare

State-wide Children's Resource Program

Steepe, Caroline

Suitability Panel

Sunraysia Community Health Services Ltd

Take Two Partnership

Taket, Ann (Professor) and Barter-Godfrey, Sarah, Centre for Health through Action on Social Exclusion, School of Health and Social Development, Faculty of Health, Deakin University

Turner, Linda (Associate Professor), Counselling and Social Work Faculty, School of Health, University of New England

UnitingCare Gippsland

UnitingCare Harrison

The University of Melbourne and Austin Health (supplementary submission)

Upper Murray Family Care

Upper Murray Family Care (supplementary submission)

VANISH Inc

Vaughan, Jenny

Vicpsychplus

Victoria Legal Aid no. 1

Victoria Legal Aid no. 2

Victorian Aboriginal Child Care Agency

Victorian Aboriginal Community Controlled Health Organisation

Victorian Aboriginal Community Services Association Limited

Victorian Aboriginal Health Service Co-operative Ltd

Victorian Aboriginal Legal Service Co-operative Limited

Victorian Alcohol and Drug Association

Victorian Association of Maternal and Child Health Nurses

Victorian Child Death Review Committee

Victorian Council of Social Service

Victorian Equal Opportunity and Human Rights Commission

Victorian Forensic Paediatric Medical Service

Victorian Heads of Schools and Programs of Social Work

Victorian Mental Health Reform Council

Victorian Youth Mentoring Alliance

Virtue, Kylie

Webster, Susan M, General Practice and Primary Health Care Academic Centre, The University of Melbourne

Wesley Mission Victoria

Western Integrated Family Violence Partnership

Whitelion Inc

Wimmera UnitingCare

Windermere Child and Family Services

Youth Affairs Council of Victoria Inc

Youthlaw

YSAS Pty Ltd

3. *List of Public Sittings and organisations and individuals making verbal submissions*

Eighteen Public Sittings were held and 140 verbal submissions were made by organisations and individuals in 2011. The first Public Sitting, held on 28 February 2011, was an information session at which the Inquiry's process was outlined and the Guide to making submissions was released. The following tables provide details of the Public Sittings including the organisations and individuals which made verbal submissions.

Melbourne 28 June: 17 submissions

Organisations (8)	Individuals (6)
Centre for Excellence in Child and Family Welfare Inc	Mr Edwin Carter
Melbourne Victims' Collective	Mr Bernie Chatley
North East Metro Child and Family Services Alliance	Ms H
Odyssey House Victoria	Ms Jatinder Kaur
Playgroup Victoria	Ms Belinda Ord
Post Placement Support Service (Vic) Inc	Mr Smith
The University of Melbourne	Private (3)
Victoria Legal Aid	

Melbourne 5 July: 17 submissions

Organisations (11)	Individuals (6)
Anglicare Victoria	Ms C
Anglicare Victoria, MacKillop Family Services, Victorian Aboriginal Child Care Agency, Berry Street, The Salvation Army, Centre for Excellence in Child and Family Welfare, Mr Michael Wyles SC	Mr Michael Donnelly
Care Leavers Australia Network	Ms Bernadette Marantelli
Community Child Care Association Inc	Mr R
Islamic Council of Victoria	Mr Doug Smith
JacksonRyan Partners	Mr W
Peninsula Drug and Alcohol Program	
Prime Focus Consulting	
Respite Care Consortium	
The Salvation Army	
The University of Melbourne	

Geelong 18 May: 8 submissions

Organisations (4)	Individuals (4)
Bethany Community Support	Mr A
Glastonbury Child & Family Services	Ms L
MacKillop Family Services	Mr P
Victoria Legal Aid	Mr A

Ballarat 25 May: 5 submissions

Organisations (4)	Individuals (1)
Brophy Family and Youth Services	Mr Paul Auchettl
Child and Family Services Ballarat Inc	
Colac Area Health	
The Royal Children's Hospital	

Bendigo 1 June: 19 submissions

Organisations (8)	Individuals (8)
Bendigo and District Aboriginal Cooperative	Dr Ken Armstrong
Bendigo Regional Clinical School, Monash University	Ms E and Ms S
Care With Me Inc	Ms Rhonda Friswell
Centre Against Sexual Assault Loddon Campaspe	Ms H
Centre for Non-Violence	Ms K
Independent Pastoral Care	Ms M
Loddon Campaspe Community Legal Centre	Ms L
St Luke's Anglicare	Mr Dennis Robinson
	Private (3)

Morwell 8 June: 7 submissions

Organisations (2)	Individuals (5)
Baw Baw Shire Council	Mr Gerald Laws
Quantum Support Services	Ms Trish McCluskey and Ms Pauline McCluskey
	Mr Alan Tatlow
	Mr Steven John Unthank
	Mr Peter van de Burgt

Mildura 16 June: 3 submissions

Organisations (2)	Individuals (1)
Mallee Family Care	Ms Bronwyn Williams
Northern Mallee Local Learning & Employment Network	

Shepparton 30 June: 10 submissions

Organisations (4)	Individuals (6)
FamilyCare	Imam Eljam Bardi
Njernda Aboriginal Corporation	Mr Brian Birrell
UnitingCare Cutting Edge	Mr Frank Clinton
Victoria Legal Aid	Ms Desley Harris
	Ms M
	Mr S

Broadmeadows 7 July: 13 submissions

Organisations (8)	Individuals (4)
Anex	Ms Vicky Chettleburgh
Australian Nursing Federation (Victorian Branch)	Dr Senem Eren
Broadmeadows Uniting Care	Dr David James
Care With Me Inc	Mr Kim Rea
CatholicCare	Private (1)
Centre for Excellence in Child and Family Welfare Inc	
Victorian Aboriginal Child Care Agency	
Victorian Mental Health Reform Council	

Werribee 8 July: 12 submissions

Organisations (5)	Individuals (4)
Baptcare	Mr Ray Caruana
Care With Me Inc	Mr Andrew Kauler
Colac Area Health	Mr S
The University of Melbourne and Austin Health	Ms Justine Webse
Whitelion Inc	Private (3)

Dandenong 11 July: 16 submissions

Organisations (10)	Individuals (6)
Australian Services Union	Mr C
Communication Rights Australia	Ms F
EACH Ltd	Ms Aza Katar
La Trobe University	Ms M
Family Life	Ms Q
Jesuit Social Services	Ms Valerie Rand
Life Without Barriers	
Menzies Incorporated	
Mission Australia	
Turning Point Drug & Alcohol Centre	

Warrnambool 15 July: 3 submissions

Organisations (3)	Individuals (0)
Community Connections (Vic) Ltd	
South West Healthcare	
Take a Break Occasional Childcare	

Horsham 19 July: 5 submissions

Organisations (3)	Individuals (0
Grampians Community Health	
Victoria Legal Aid	
Wimmera UnitingCare	

Bairnsdale 22 July: No submissions

The Inquiry conducted informal discussions with attendees

Wodonga 25 July: 5 submissions

Organisations (2)	Individuals (1)
Mungabareena Aboriginal Corporation	Ms Rhonda Janetzka
Upper Murray Family Care	Private (2)

Echuca 26 July: No submissions

The Inquiry conducted informal discussions with attendees

Swan Hill 28 July: 2 submissions

Organisations (1)	Individuals (1)
Mallee Family Care	Ms Roslyn Lowe

4. List of visits, consultations and meetings conducted in 2011

Aboriginal Justice Forum

Anglicare Victoria (Kinship Care Support Service)

Australian Childhood Foundation

Berry Street, Richmond

Berry Street, Morwell

Berry Street Therapeutic Foster Care Program, Shepparton

Berry Street and Victorian Aboriginal Child Care Agency "Two Ways Together" Seminar

Brophy Family and Youth Services

Cara Inc

Centre for Community Child Health, The Royal Children's Hospital

Dr Charles Pascal, Special Advisor, Ontario Early Learning Strategy

Child FIRST Narre Warren

Children's Commissioner of Queensland and Assistant Commissioner

Children's Court of Victoria

Children's Court Bar Association

Children's Court Clinic

Children's Court, Geelong

Children's Court, Moorabin

Children's Court of Western Australia

Children's Services Coordination Board

Collingwood Neighbourhood Justice Centre, Magistrate David Fanning

Commissioner for Children and Young People, Western Australia

Community and Public Sector Union

Connections Uniting Care

Darebin Family Violence Response Unit

Department for Child Protection, Western Australia

Department of Education and Early Childhood Development, acting Secretary and Secretary

Department of Health, Secretary

Department of Health, Integrated Health

Department of Human Services, Secretary

Department of Human Services After Hours Service and Streetworks

Department of Human Services briefing on Protecting children, changing lives

Department of Human Services Bairnsdale office

Department of Human Services Ballarat office

Department of Human Services Bendigo office

Department of Human Services Geelong office

Department of Human Services Horsham office

Department of Human Services Mildura office

Department of Human Services Preston office

Department of Human Services Secure Welfare Facility, Maribyrnong and Ascot Vale

Department of Human Services Shepparton office

Department of Human Services Swan Hill office

Department of Human Services Warrnambool office

Department of Human Services Wodonga office

Department of Justice, Secretary

Department of Justice

Department of Treasury and Finance, Secretary

Domestic Violence Resource Centre Victoria

Domestic Violence Victoria, Melbourne

Dr Andrew Turnell, Child Protection Consultant

Enhanced Best Start, Shepparton

Family Court, Melbourne

GordonCare, Highett

Hume City Council Maternal Child Health Services

King Edward Memorial Hospital, Subiaco,
Western Australia

Law Institute of Victoria

Legal Aid Western Australia,

MacKillop Family Services (residential care services)

MacKillop Family Services (Youth Advisory Council)

Mildura Best Start Program

Multidisciplinary Centre, Frankston

Multidisciplinary Centre, Mildura

Ms Naomi Eisenstadt CB, Senior Research Fellow, Department of Education and Social Policy,
University of Oxford

Njernda Aboriginal Corporation, Echuca

Ombudsman, Western Australia

Professor Eileen Munro, Professor of Social Policy, London School of Economics

Professor Frank Oberklaid, acting Chair, Victorian Children's Council

Professor Marie Connolly, Chair and Head of Social Work,
School of Health Sciences, University of Melbourne

Professor Stephen Smallbone, University of Queensland

Queen Elizabeth Centre, Noble Park

Queensland Department of Communities

Rumbulara Centre, Shepparton

Swan Hill Aboriginal Family Service

The Royal Children's Hospital Gatehouse Centre

The Royal Children's Hospital frontline staff

The Royal Children's Hospital, Victorian Forensic Paediatric Medical Service and Governance Project Team

Signs of Safety Conference, Perth

St Luke's Anglicare

Victoria Police

Victoria Police Chief Commissioner

Victoria Police Darebin Family Violence Response Unit

Victoria Police Sexual Assault and Child Abuse Project (and Sexual Offence and Child Abuse Investigation Teams forensic interview)

Victorian Aboriginal Child Care Agency, Brunswick

Victorian Aboriginal Health Service, Collingwood

Victorian Child Death Review Committee, Chair

Victorian Child Safety Commissioner

Victorian Child Safety Commissioner, CREATE Foundation Victoria, Centre for Excellence in Child and Family Welfare, Youth Affairs Council of Victoria

Victorian Children's Council

Victorian Law Reform Commission

Victorian Ombudsman

Victorian State Coroner

Yappera Multifunctional Aboriginal Children's Centre, Thornbury

Youth Parole Board

5. Consultations

Consultations with Aboriginal communities conducted in 2011:

Mildura

Shepparton

Dandenong

Warrnambool

Bairnsdale

Thornbury

Consultations with frontline workers conducted in 2011:

Community service organisations:

Gippsland region

Melbourne CBD

Barwon South Western region

Department of Human Services:

Gippsland region

Southern Metropolitan region

Consultation with DHS managers, Melbourne CBD

Barwon-South Western region

CREATE consultations with children and young people conducted in 2011:

Dandenong

East Brunswick (VACCA)

Melbourne

Shepparton

Consultation with workers from culturally and linguistically diverse community organisations conducted in 2011:

Melbourne

6. List of Reference Group members and meetings conducted in 2011

The Reference Group met on three occasions: 13 April, 6 June, 1 August 2011. Summary notes relating to the meetings have been published on the Inquiry's website.

Members:

Mr Kevin Zibell, Board President, Centre for Excellence in Child and Family Welfare and CEO, Child and Family Services Ballarat

Dr Lynette Buoy, CEO, Centre for Excellence in Child and Family Welfare

Professor Chris Goddard, Child Abuse Prevention Research Australia, Monash University

Ms Bernadette Harrison, Outreach and Enhanced Maternal Child Health Team Leader, City of Greater Dandenong

Ms Ann Rowley, Acting State Coordinator, CREATE Foundation

Ms Chris Asquini, Executive Director, Children, Youth and Families Division, Department of Human Services

Professor Cathy Humphreys, Alfred Felton Chair of Child and Family Welfare, Department of Social Work, The University of Melbourne

Ms Fiona McCormack, CEO, Domestic Violence Victoria

Ms Katie Hooper, Executive Officer, Foster Care Association of Victoria Inc

Ms Anne McLeish OAM, Director, Kinship Carers Victoria

Ms Caroline Counsel, President, Law Institute of Victoria

Mr Greg Hancock, Principal, Lilydale Heights Secondary School

Dr Sandra Radovini, Director, Mindful

Ms Jan Black, Policy Adviser, Municipal Association of Victoria

Dr Stefan Gruenert, CEO, Odyssey House/FADNET

Dr Peter Eastaugh, Pediatrician, Shepparton

Mr Bevan Warner, Managing Director, Victoria Legal Aid

Ms Wendy Steendam, Assistant Commissioner, Victoria Police

Ms Muriel Bamblett, CEO, Victorian Aboriginal Child Care Agency

Mr John Zika, Executive Director, Victorian Cooperative on Children's Services for Ethnic Groups (VICSEG) New Futures

Notes:

For the 1 August 2011 meeting Ms Marilyn Webster, Director of Research and Social Policy, Centre for Excellence in Child and Family Welfare attended for Dr Lynette Bouy; Dr Neerosh Mudaly for Professor Chris Goddard and Mr Michael Brett Young, CEO, Law Institute of Victoria for Caroline Counsel.

For the 6 June 2011 meeting Ms Judy Small attended for Mr Bevan Warner and Dr Neerosh Mudaly for Professor Chris Goddard.

For the 13 April 2011 meeting Mr Michael Brett Young, CEO, Law Institute of Victoria attended for Caroline Counsel.

Appendix 3: Summary CREATE Foundation Final Report

Introduction and background

The CREATE Foundation is the peak body representing the voices of all children and young people in out-of-home care.

The CREATE Foundation was contracted by the Inquiry to consult with children and young people to seek their views and opinions about the out-of-home care system in Victoria. The foundation prepared a report for the Inquiry based on the views and opinions of children and young people who participated in an on-line Be.Heard survey and four focus groups in June and July 2011 organised and facilitated by the CREATE Foundation.

CREATE Foundation Victoria states that it has membership of approximately 1,000 children and young people with current or previous out-of-home care experience. In total 29 children and young people aged between eight and 24 years participated in the focus groups and 27 children and young people participated in the on-line Be.Heard survey. Given the small sample and the over-representation of young people placed in residential care, and the over-representation of older children and young people, the respondents were not a representative sample of children and young people with current or past out-of-home care experience.

The full final report prepared by the CREATE Foundation is available from the Inquiry website. The report's Summary and discussion section is reproduced below. These are not necessarily the views of the Inquiry.

CREATE Foundation final report: Summary and discussion

That the views and opinions of children and young people are incorporated into the Inquiry consultations is integral to the conduct of the Inquiry. These are the very children and young people who are the direct and primary stakeholders of the child protection system in Victoria.

Any results from this consultation process cannot be generalised to the broader care population due to the number of important limitations of the data derived from the consultations. These limitations include:

- The relatively small sample size (56 children and young people):
- The possible overlap between the two groups as some participants in the focus groups may have also completed the survey;
- The loading of respondents from residential care compared to other care type; and
- The age of the respondents compared to the population of Victorian children in out-of-home care.

Despite the limitations of the data, the views and opinions provided through the survey and the focus groups are a rich source of information and provide a snapshot of the out-of-home care sector in Victoria as experienced by the children and young people. The limitations of the data also does not diminish in any way the significance, for the children and young people involved, of participating in the consultation processes associated with the Inquiry.

It became evident from the discussions and feedback of these children and young people that they have clear and defined opinions and ideas about what and how they feel on a range of issues and there were recurring and common themes that emerged from both consultation types.

A summary of the themes and issues as identified by the children and young people follow.

Workers

Questions in the area of what made a good worker were designed to establish whether children and young people had a sense of relationship with their workers, and if not, then what could help to establish that. The theme of having someone with whom they had an emotional connection was regarded by the children and young people as being critically important to their wellbeing. When asked to identify what was good about their worker, the children and young people commonly identified the desire to have a worker with whom they could have a connection or real relationship.

Worker skills and qualities such as being accessible, able to listen, understand their needs and still have fun were regarded as significant assets.

- 'Workers are good when they share something about themselves, and you develop a bond.'
- It was also clear that children and young people didn't appreciate circumstances that could prevent a worker from being readily available to them.
- 'My worker is hard to contact.'

This perspective, that children and young people really value workers who take the time to listen to them, have good communications skills, and have a caring attitude, is supported by the results to the question asking what could your worker do to help you more. Commonly the participants in the focus groups and the survey said that they wanted workers who would engage with them and listen.

The quality of the relationship between a child or young person and their worker is critical to outcomes for the child or young person and cannot be standardised by legislation, procedures or policy. It's on this basis that case work and case management is operationalised and the relationship can make it easier or harder for a child to get what they need to ensure their safety and wellbeing.

Participation

Participation of children and young people in decisions that impact on them is a fundamental child protection principle. Young people participating in the survey believed that most times their views were considered in decision making processes and that they were able to have their say. It should be noted as well that one-fifth of the respondents believed they weren't involved in decision making at all.

Young people participating in the focus groups believed their views were not always taken into account. Fundamental issues that underpinned this were cited by the children as not being listened to and as noted in some focus groups, that they didn't get to see their workers often enough to be involved in decision making processes.

- 'I don't find out about meetings until after they happen.'
- 'It would be great if they listened more.'

Family and culture

The area of family contact was not fully explored in these consultations. The question that related to this topic asked whether the child or young person responding to the question would like more or less contact with their family, or if they would like the level of contact to remain the same. The majority of respondents to this question indicated they would like the level of contact to increase or remain the same.

Some young people in the focus groups raised the issue that they felt a sense of unfairness about what they saw as inequity in the levels of family contact between siblings with parents. The commonly held view of those children and young people affected by this issue, of the reasons for differing levels of contact between siblings was due to being in a different placement and having different workers. To protect the young people's privacy, other reasons that could explain decision making regarding different levels of contact between siblings with parents was not explored further with them.

Safety

Safety has great significance for children and young people who have experienced or been at risk of abuse, trauma, grief and loss. The majority of children who responded to this question reported feeling very safe in their current placement with 80% stating that they felt reasonably to very safe in their placement.

To ensure their safety is the primary basis for children entering care. The level of response indicating they felt a strong sense of safety is a reflection of the level of confidence that children and young people have in the out-of-home care system.

Placements – home-based care

The children and young people who were involved in this consultation process had some positive comments about the out-of-home care sector overall and particularly in relation to their carers.

The majority of children and young people who responded to the survey said they were happy in their current placement. Feedback from the children and young people responding to the survey indicated that having a home-based placement where they felt cared for and included as part of a family were the best things their carer could provide. During the focus groups the children and young people were asked what would be their dream placement. Most frequently, they said that their dream placement was the one they were currently living in.

Their comments showed they had an awareness of their care situation and an appreciation for the efforts of their carers.

- 'She loves me and cares for me, looks after me when I am sick and sad. They love me like I am their own daughter.'
- 'I have a great placement – good kids, good carers, help when I need it and stability.'

- 'I think being in foster care is better than being at home. I have been in the same foster care placement for 10 years and it's good to know that someone will take care of us.'

Placements – residential

The majority of young people involved in the focus groups were placed in residential units. Although a small sample of children and young people were consulted in this process, the issues raised by them in relation to their residential placement are concerning. It's possible that these concerns are isolated to this sample of young people however it is equally possible that the issues are more widespread and this small group of young people truly represent the residential population.

There were a number of concerns raised that related to their physical and emotional safety and most often being at risk from other young people living in the same unit. The issue was raised in one focus group by young women about feeling pressured to engage in sexual activities with male residents. It is difficult to determine if this is a widespread issue, as it was not clarified if the perceived pressure came from the male residents, other female residents, if it was self directed from the young women's own values and beliefs or whether there was a culture within the units that contributed to the feeling of being pressured to engage in sexual activities.

Similarly, how widespread were incidents of physical abuse of one resident by another is difficult to tell. One young person in a focus group related their experience of being granted an intervention order against a fellow resident as a form of protection from physical harm. Another telling comment by a survey respondent was:

- 'You get assaulted in the resi units.'

Of greater concern was the number of comments that came from young people about the effect of having young people in the unit with more complex or higher support needs than their own. The responses to what was not so good about their placement highlighted the issues of having a number of young people in one placement, all with individual histories of abuse and trauma.

- 'There needs to be an assessment of young people before they come in to the resi, so that there is no contamination.'
- 'Peer pressure affects your outcomes.'
- 'Contamination stops young people from going to school.'
- 'Contamination from drugs and alcohol and crime.'

Young people living in residential units are often young people with complex and diverse needs. Placements in residential care needs to be made with consideration of the child or young person's strengths and needs, individual abuse and trauma history, culture and developmental needs as well as the needs of other young people already residing with the service. Although the intention is that the placement is a response to each child's physical, social and emotional needs, comprehensive assessment and matching is needed to ensure that each child will not be further traumatised or harmed by the experience.

Overall out-of-home care system

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.

The children and young people were evenly distributed in how they rated the effectiveness of the out-of-home care sector overall with no clear signs that the system was doing its job poorly or very well. When asked to identify what were the best things and what were the worst things about the overall system, children's comments often reflected their satisfaction with the overall system by the interactions they have with the adults who represent that system.

For children and young people who are in out-of-home care, they need to place their trust in adults, often unknown to them, to care for them and to make decisions in their best interests. Their comments highlight that for them the system is about the human interactions and relationships they have with the people on whom they rely for safety and security.

- 'There is no shortage of workers who actually care about the children.'
- 'The department doesn't listen and only wants you to do what they want.'

(Source: CREATE Foundation 2011, pp. 28-32).

Appendix 4: Executive summary – The economic and social cost of child abuse in Victoria, 2009-10, Deloitte Access Economics

Child abuse and neglect are associated with many adverse outcomes for the individuals concerned and the community more generally. In brief, child abuse and neglect have been associated with the following:

- Physical injury and illness (brain injuries, central nervous system injuries, fractures, reproductive health problems, ocular damage, sexual dysfunction, irritable bowel syndrome, heart disease and other illnesses);
- Mental illnesses (including anxiety and depression, eating disorders, post-traumatic stress disorder and suicide);
- High risk sexual behaviour;
- Substance misuse;
- Poor social functioning and participation in society;
- Adult victimisation;
- Developmental delay and impairment, cognitive and neurological impairment, low academic achievement;
- Poor employment and earnings outcomes;
- Delinquency and adult criminal behaviour, and subsequent victimisation of children; and
- Homelessness and greater rates of use of welfare.

Deloitte Access Economics was appointed to prepare an estimate of the cost of child abuse in Victoria in 2009-10 based on the method used in Taylor et al. 2008.

Incidence and prevalence of abuse in Victoria

Both incidence and prevalence estimates were generated for this report:

- The **incidence** of child abuse represents the number of children abused for the first time in 2009-10. The incidence costs measure the associated costs of abuse over each abused person's lifetime; and
- The **prevalence** of child abuse in this case is an annual measure, representing the number of children abused in 2009-10 – whether for the first time or not. The prevalence costs measure the associated costs of abuse or neglect which occurred in 2009-10.

There is a great deal of uncertainty about the extent of abuse and neglect which occurs, more uncertainty than for other types of physical or mental illness, because of the nature of the act and the harm caused:

- The highest rates of abuse and neglect occur among children aged less than five years old. These children are generally unable to articulate their experience. Moreover, they may be unable to judge what types of behaviour are unacceptable until much later in life;
- Those who have experienced abuse are likely to have suffered trauma and may be unwilling to openly discuss or revisit their experience. Furthermore, there may be a stigma attached to revelations of abuse and uncertainty about how such revelations are received;
- Children who have experienced abuse may have a reduced capacity to trust and may lack self-esteem. These characteristics tend to mean they are unwilling to report abuse; and
- Abuse can be difficult to detect and diagnose by others.

Moreover, efforts to synthesise the many studies of the extent of occurrence of child abuse and neglect are hampered by the following:

- Differences in scope (the type of abuse studied);
- Differences in definitions of abuse and thresholds for determining abuse;
- Differences in counting methods; and
- Differences in sample characteristics.

Certain types of sample characteristics, counting methods, and definitions can introduce biases into estimates and it is difficult to adjust for this given the lack of knowledge on which to base methods for adjustment. Given the uncertainty surrounding estimates of the prevalence and incidence of abuse, two sets of estimates are reported here – a lower bound and a best estimate. Both are conservative.

Lower bound

The lower bound estimate of prevalence and incidence is based on the number of children who were the subject of a substantiation by the Victorian child protection system. Substantiations refer to cases which have been investigated and it is concluded that the child has been, is being, or is likely to be, abused, neglected or otherwise harmed. A child can be the subject of more than one substantiation.

The **prevalence** estimate was based on the number of Victorian children in substantiations adjusted upwards for investigations still in progress at the end of the financial year and for cases where a decision not to substantiate was followed by a subsequent decision to substantiate. The lower bound estimate of prevalence is around six Victorian children aged 0-17 years old per 1,000.

Lower bound **incidence** estimates were derived by adjusting the prevalence estimates to remove the proportion of Victorian children who were subject to repeated abuse over a number of years. The proportion of children subject to repeated abuse or neglect lasting more than one year was derived from a literature review (see Taylor et al. 2008). The lower bound estimate of incidence is around four Victorian children aged 0-17 years old per 1,000.

Notably, estimates of abuse based on substantiations data are likely to underestimate the extent of abuse. In the main, this is because a substantial amount of abuse is not reported to authorities for reasons explained above. In addition, counts of substantiations reflect the legislative and practice arrangements in place, and the proportion of notifications that are investigated. In 2009-10 in Victoria, close to 29 per cent of notifications were investigated.

Best estimate

The best estimate of prevalence and incidence is drawn from self-reports of child physical and sexual abuse by adults based on their recollections of childhood from the Australian Bureau of Statistics (ABS) Personal Safety Survey conducted in 2005 (ABS 2006c). The survey has not been updated since the original report (Taylor et al. 2008) was released. The survey found that the lifetime prevalence of child physical or sexual abuse was around 17.8 per cent. The best estimate of **prevalence** used in this report was derived by converting the lifetime prevalence rate from the ABS survey to an annual prevalence rate for Victoria (just under 3.7 per cent).

Best estimates of **incidence** in this report were calculated by factoring up the lower bound incidence estimates for the difference in between the lower bound prevalence rate (0.6 per cent) and the ABS Personal Safety Survey estimate of one year prevalence (3.7 per cent). The best estimate of incidence is just under 27 Victorian children aged 0-17 years per 1,000.

The best estimate also understates the occurrence of abuse because:

- The ABS survey only asked about physical and sexual abuse, and other types of abuse (emotional or psychological and witnessing family violence) and neglect were excluded; and
- The sample excluded people living in institutions and people living in very remote areas (the former are arguably more likely to have experienced child abuse) and people who died as a result of abuse.

The 'best estimates' need to be treated with caution because the survey responses are likely to have been affected by a number of factors including:

- Sensitivities associated with talking about experiences of child abuse, as discussed earlier; and
- Reliance by respondents on recall, which can introduce some uncertainty, particularly in recalling episodes of abuse between the ages of 0-4 years when other data suggests abuse rates are relatively higher than for older children.

Scope of costs

There are financial costs associated with abuse (e.g. the costs of service provision), as well as non-financial costs (loss of wellbeing). The financial costs for Victoria estimated in this report include the following:

- Health system costs including:
  - the costs of treating injuries directly resulting from physical abuse and fatal abuse; and
  - long term (downstream) costs of illnesses and premature death experienced by adults who were abused as children. Types of illnesses included are: suicide, physical injuries, depression, anxiety, and substance misuse (including alcohol and drugs);
- Education system costs associated with potentially poorer educational achievement leading to additional assistance required at school;

- Productivity losses due to poorer employment and earnings outcomes resulting from lower than average rates of completing Year 12 by children in out of home care (OOHC);
- Justice system costs including:
  - the cost of care and protection orders;
  - Coroners Court costs of investigating child deaths or suspicious deaths;
  - the costs associated with investigating abuse such as police investigations, prosecution costs and the costs of incarceration of perpetrators of child abuse;
  - victim support; and
  - the costs of crimes committed in cases where children who experienced abuse go on to commit crimes in later life.
- The costs of the child protection system and intensive family support services;
- The costs of greater than average use of crisis accommodation by families in which abuse has occurred, and the cost of greater than average use of public housing by children leaving OOHC; and
- Deadweight losses associated with additional welfare payments and government expenditures associated with child abuse. While welfare payments are not in themselves economic costs (they are transfer payments), they are associated with efficiency losses (or to use economic terminology – deadweight losses). Deadweight losses reflect the resources required to administer the taxation and welfare systems, the associated costs of compliance activities and the behavioural distortions resulting from the incentives associated with taxation and welfare.

The **non-financial** cost, or loss of wellbeing resulting from child abuse, is also estimated here, measured in disability adjusted life years (DALYs). A monetary valuation is placed on the loss of wellbeing using the Commonwealth Department of Finance and Deregulation, Office of Best Practice Regulation estimate of the value of a statistical life year. However, this value cannot be added to the financial costs and is for comparative purposes only.

Caveats and considerations

Limitations to data and evidence mean that there will naturally be a margin of uncertainty surrounding the magnitude of the estimated costs. In particular, there is a paucity of studies with long term follow up of children who experienced abuse or neglect – and the studies that are available have very small sample sizes. Hence, it is very difficult to quantify the long term (or downstream) impact of abuse and neglect and thus capture the costs.

It is difficult to isolate the extent to which ill health, substance misuse, poor social functioning, adult victimisation, poor employment and earnings outcomes and the other adverse outcomes listed above can be directly attributed to abuse. Risk factors for child abuse and neglect include low socioeconomic status leading to economic stress and disadvantage, poor parental mental health, parental substance misuse, family disruption, and disability of the child. These risk factors for child abuse are themselves associated with the undesirable outcomes above, and hence confound efforts to isolate the impact of abuse. Where possible, the methodology here uses parameters which adjust for confounding factors such as socioeconomic circumstances.

It has not been possible to present estimates which reflect the spectrum of severity of harm resulting from abuse and neglect. This is unfortunate because some children experience extreme harm (including premature death, severe disability, and severe depression) and for these individuals the costs of abuse are very high. However, it is difficult to predict the severity of harm based on the type or nature of abuse because some children are more resilient than others, or there may be factors in the child's environment which moderate the harm resulting from abuse (for example, an alternative influential and stable care figure). In addition, for many of the cost components, the data and evidence available do not allow the systematic adjustment of costs to account for different degrees of, or severity of, harm.

Some children who survive abuse may experience extreme loss of wellbeing but no (or few) financial costs because they do not use health or other support services. For example, children may survive abuse but, as a result, exist with lifelong severe depression for which they never seek treatment. In this report, these cases will be reflected in the loss of wellbeing from depression (counted as DALYs).

Prevalence costs

In total, the financial costs in 2009-10 of child abuse and neglect in Victoria were estimated to lie between $876.6 million and $1.0 billion (table 1). In addition, abuse was also associated with loss of wellbeing and premature mortality estimated at between 1,384 and 6,866 DALYs, and valued at between $221 million and $1.1 billion.

The largest component of the financial costs was Victorian Government expenditure on child protection, OOHC, intensive family support services and the Office of the Child Safety Commissioner.

There is no difference between the lower bound and best estimate for many of the costs. This reflects the methodology used. Not all of the estimated costs vary with prevalence.

- In accordance with the methodology, estimates of productivity losses associated with premature death remain the same for the lower bound and best estimate because the number of deaths is fixed as a proportion of the Victorian population by age and gender.
- Spending on the child protection system and intensive family support services is fixed at the amount spent by the government in 2009-10.
- Public housing costs are based on the number of children leaving OOHC in 2009-10 (which was assumed not to vary with different estimates of prevalence).
- The costs of the Supported Accommodation and Assistance Program (SAAP) and crime, courts and victim support are estimated as the proportion of expenditure accounted for by the relevant services (including justice system services) supplied.

Table 1 Summary of prevalence costs, Victoria, 2009-10

Prevalence	Units	Lower bound	Best estimate
	Number of children	7,340	44,740
Financial costs			
Health system	($'000)	20,367	124,164
Education	($'000)	3,516	14,864
Productivity Losses – lower employment	($'000)	989	1,753
Productivity losses – premature death	($'000)	1,820	1,820
Child protection, OOHC, intensive family support and Child Safety Commissioner	($'000)	518,128	518,128
Public housing	($'000)	3,942	3,942
SAAP	($'000)	16,297	16,297
Crime, courts and victim support	($'000)	103,498	103,498
Second generation crime	($'000)	354	2,157
Deadweight losses	($'000)	207,682	241,374
Total financial costs	($'000)	876,593	1,027,997
Burden of disease			
DALYs	DALYs	1,380	6,870
Value of DALYs	($'000)	221,242	1,097,620

Incidence costs

In total, the financial costs of child abuse and neglect which occurred for the first time in 2009-10 in Victoria were between $1.6 billion and $1.9 billion . In addition, abuse was also associated with loss of wellbeing and premature mortality of between 1,315 and 7,640 DALYs. The loss of wellbeing has been valued at between $210 million and $1.2 billion. Victorian Government expenditure on child protection, OOHC, intensive family services and the Office of the Child Safety Commissioner accounted for the majority of the incidence costs.

Consistent with the prevalence cost, there is no difference between the lower bound and best estimate of many of the incidence costs. The same types of costs are fixed as for prevalence. Importantly, this has an impact on estimates derived for the average lifetime cost of abuse per child in 2009-10. The estimate **financial** cost based on the lower bound prevalence is of the order of $300,000 and for the best estimate of prevalence the lifetime **financial** cost is up to $60,000. Notably – this estimate **excludes** loss of wellbeing (DALYs).

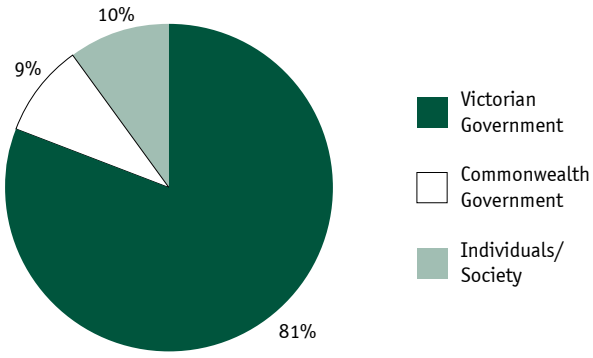
Table 2 Summary of incidence abuse and costs, Victoria, 2009-10

	Units	Lower bound	Best estimate
Incidence	Number of children	5,390	32,850
Financial costs			
Health system	($'000)	29,781	187,660
Education	($'000)	6,372	38,693
Productivity Losses – lower employment	($'000)	11,015	67,150
Productivity losses – premature death	($'000)	37,084	37,084
Child protection, OOHC, intensive family support and Child Safety Commissioner	($'000)	1,032,141	1,032,141
Public housing	($'000)	25,300	25,300
SAAP	($'000)	11,978	11,978
Crime, courts and victim support	($'000)	74,443	74,443
Second generation crime	($'000)	260	1,585
Deadweight losses	($'000)	351,245	411,392
Total financial costs	($'000)	1,579,619	1,887,428
Lifetime financial costs	($'000)	293	57
Burden of disease			
DALYs	DALYs	1,315	7,640
Value of DALYs	($'000)	210,064	1,221,055

How the costs are distributed

The majority of the financial costs of child abuse and neglect are incurred by the Victorian Government (Figure 1). These shares are approximate because Commonwealth contributions (via Special Purpose Payments) are treated as State expenditure. It is important to reiterate that the non-financial costs (the loss of wellbeing experienced by Victorian children who have been abused or neglected) are not included in Figure 1. These non-financial costs are incurred by the children themselves. So the share of the total costs of abuse experienced by individuals is much higher than 10%.

Figure 1 Distribution of financial costs



Source: Deloitte Access Economics 2011, Cost of Child Abuse and Neglect in Victoria, 2009-10

Appendix 5: Technical note on the main sources of data used throughout the Report

1 Introduction

Throughout the Report the Inquiry has sought to present the most reliable and up-to-date information on Victoria's system for protecting children. As such, the Report has incorporated a range of information from published and unpublished sources.

The sources of all published information used by the Inquiry are referenced where they appear in the Report. These include past reports on Victoria's system for protecting children, evidence from other jurisdictions, academic literature, organisations' annual reports, budgets and others. The Inquiry has also made extensive use of two annual series on child protection in Australia:

- The Steering Committee for the Review of Government Service Provision, *Report on Government Services 2011*; and
- The Australian Institute of Health and Welfare (AIHW), *Child Protection Australia 2009-10*.

The Inquiry was also provided with a large volume of unpublished information from Victorian Government departments and other organisations. This information is referenced throughout the report as information provided to the Inquiry. Where the Inquiry made significant calculations using unpublished information it is referenced as the Inquiry's analysis of that information.

2 Forecasts of child protection reports from the 2011 birth cohort

2.1 Background

In 2003 the Department of Human Services (DHS) estimated that 19.3 per cent of children born in 2003 would be the subject of a child protection report at some time before reaching age 18 – equivalent to about one in five children. Since this time the number of reports of suspected child abuse or neglect in Victoria has increased substantially, justifying a recalculation of the DHS figures.

With data provided by DHS and the Department of Planning and Community Development (DPCD) it is possible to replicate the 2003 DHS methodology on smaller geographic scale to gain an insight into the differing rates of child protection reports across the state.

The 2003 estimates

In 2003 DHS estimated that 19.3 per cent of children born in 2003 would be the subject of a child protection report at some time before reaching age 18. The methodology applied by DHS can be summarised by the following:

1. DHS calculated the number of children who were reported for the first time in 2002-03 for each year of age (0 to 17) and expressed this as a rate per 1,000 children of that age in the state;
2. DHS applied these age specific first-report rates to population projections for the state to estimate the number of children born in 2003 that would be the subject of a child protection report at each year of age from zero (in 2003) to 17 (in 2020);
3. The sum of these figures was then divided by the forecast population of 17 year olds in 2020 to estimate the likelihood that a child born in 2003 would be the subject of a child protection report before turning 18.

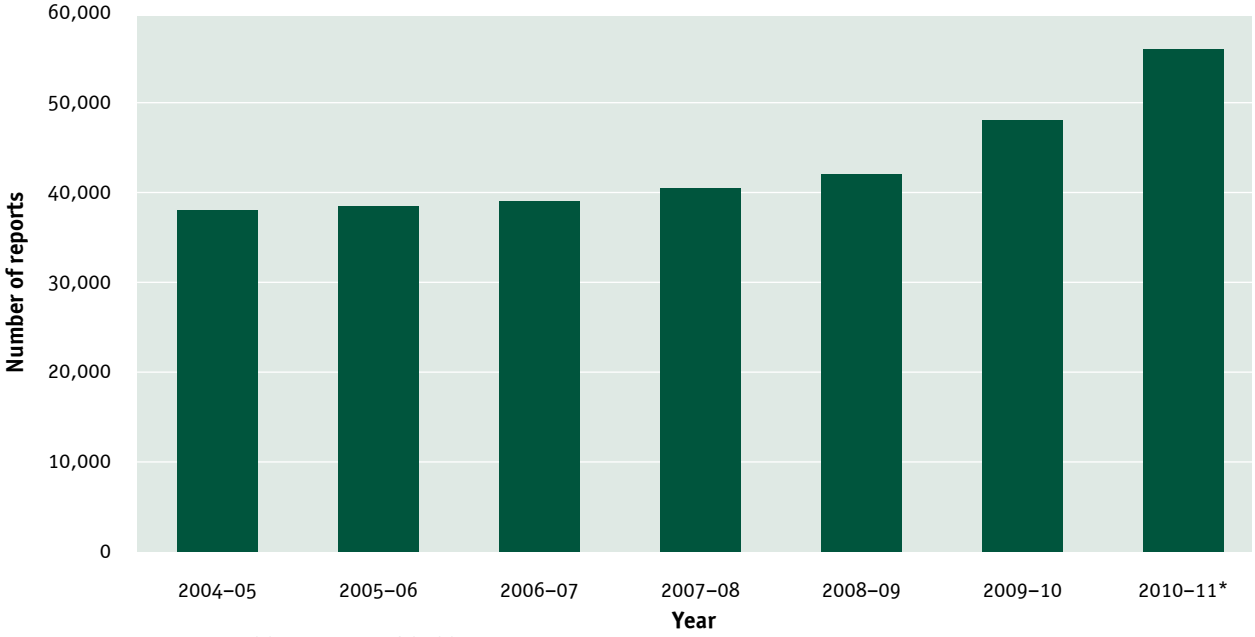
The methodology applied by DHS was reviewed by Professor Rob J Hyndman, from the Business and Economic Forecasting Unit at Monash University in 2004. The review suggested that the methodology could be improved by applying a linear forecasting method to control to forecast changes in age specific notification rates, but found that this did not change the results substantially (Hyndman 2004).

The main area of concern highlighted by the review was the accuracy of first-time report counts. The review found that in a worst case scenario, of 14 per cent duplication, the estimated rate of child protection reports for children born in 2003 would be reduced to 16.6 per cent (Hyndman 2004).

Increase in the number of child protection reports

The number of child protection reports in Victoria has increased substantially since 2003. Reports have risen in each of the last five years. In 2004-05 the AIHW reported that there were 37,523 notifications in Victoria, compared with 48,369 in 2009-10, an increase of almost 11,000. Over this time the number of reports in Victoria has increased by an average of 5.3 per cent per annum. In 2009-10 the number of Victorian reports increased by 5,518 or 12.9 per cent. In 2010-11 this figure increased by a further 15.4 per cent to 55,718.

Figure 1 Total number of child protection reports, Victoria, 2004-05 to 2010-11



Source: AIHW 2011c, Table 2.2 * Provided by DHS

2.2 Updated estimates

The Inquiry has used data provided by DHS and DPCD to produce an update to the 2003 estimates for children born in 2011, based on the number of children reported to DHS for the first time in 2009-10 and 2010-11.

Child protection reports

In 2009-10 there were around 48,300 child protection reports made in relation to approximately 37,500 children. While in 2010-11 there 55,700 reports in relation to approximately 41,500 children.

More than half of the children who were the subject of a child protection report in 2009-10 had been the subject of a report in a previous year, leaving 17,718 who were subject of a report for the first time in 2009-10. The equivalent figure in 2010-11 was 19,351.

Table 1 First child protection reports, estimated population and estimated rate of first child protection reports per 1,000 children, 2009-10 and 2010-11

	First child protection reports		Estimated population		Estimated rate of first reports per 1,000 children	
Age	2009-10	2010-11	2010	2011	2009-10	2010-11
0	2,701	2,825	69,028	71,893	39.13	39.29
1	1,394	1,449	71,727	71,174	19.43	20.36
2	1,275	1,421	71,591	72,364	17.81	19.64
3	1,214	1,332	71,176	72,227	17.06	18.44
4	1,254	1,195	68,253	71,727	18.37	16.66
5	898	1,163	66,084	68,763	13.59	16.91
6	969	1,050	65,947	66,672	14.69	15.75
7	866	1,029	65,181	66,534	13.29	15.47
8	907	967	65,038	65,743	13.95	14.71
9	736	876	65,750	65,625	11.19	13.35
10	768	880	66,502	66,324	11.55	13.27
11	791	812	66,803	67,057	11.84	12.11
12	874	831	66,484	67,373	13.15	12.33
13	827	931	67,678	67,098	12.22	13.88
14	828	1,006	68,128	68,295	12.15	14.73
15	901	894	70,154	68,990	12.84	12.96
16	500	659	70,834	71,650	7.06	9.20
17	15	31	71,816	72,919	0.21	0.43
Total	**17,718**	**19,351**	**1,228,174**	**1,242,427**	**14.43**	**15.58**

Sources: First child protection reports provided by DHS (unpublished); population data for 2010 taken from Australian Bureau of Statistics 2010b; population data for 2011 provided by DPCD (unpublished)

Projections for the 2011 birth cohort

In accordance with the methodology applied to the 2003 estimates of child protection, the age specific rates of first-time child protection reports have been applied to population projections provided to the inquiry by DPCD. This gives an estimate of the total number of first-time child protection reports that will occur for children born in 2011.

Table 2 Estimated number of first child protection reports and probability of first report for Victorian children born in 2011, based on first child protection reports in 2009-10 and 2010-11

Age	Year	Estimated Population	2009-10 reports		2010-11 reports	
			No. of 1st reports	Probability of 1st report	No. of 1st reports	Probability of 1st report
0	2011	71,893	2,813	3.9%	2,825	3.9%
1	2012	72,189	1,403	1.9%	1,470	2.0%
2	2013	72,761	1,296	1.8%	1,429	2.0%
3	2014	73,353	1,251	1.7%	1,353	1.8%
4	2015	73,908	1,358	1.8%	1,231	1.7%
5	2016	74,436	1,011	1.4%	1,259	1.7%
6	2017	74,942	1,101	1.5%	1,180	1.6%
7	2018	75,445	1,002	1.3%	1,167	1.5%
8	2019	75,961	1,059	1.4%	1,117	1.5%
9	2020	76,471	856	1.1%	1,021	1.3%
10	2021	76,958	889	1.2%	1,021	1.3%
11	2022	77,462	917	1.2%	938	1.2%
12	2023	77,979	1,025	1.3%	962	1.2%
13	2024	78,499	959	1.2%	1,089	1.4%
14	2025	79,062	961	1.2%	1,165	1.5%
15	2026	79,849	1,026	1.3%	1,035	1.3%
16	2027	81,163	573	0.7%	746	0.9%
17	2028	83,114	17	0.0%	35	0.0%
Total			**19,518**		**21,043**	

Source: Analysis of data provided by DHS and DPCD preliminary population projections (unpublished)

2.3 Results

Based on the rate of first-time child protection reports from 2009-10, the likelihood of a child born in 2011 being notified to child protection at some point before they turn 18 can be estimated by dividing the total number of first-time reports for the 2011 cohort by the estimated number 17 year olds in 2028.

This suggests that the likelihood that a child born in 2011 will be notified to child protection at some time before reaching age 18 is 23.5 per cent – slightly less than one in four.

When the same calculation is repeated based on 2010-11 first child protection report rates, the likelihood is 25.3 per cent, again around one in four. The estimate based on 2010-11 rates is higher because of the higher number of children in child protection reports for the first time in 2010-11.

The Inquiry commissioned the Statistical Consulting Centre, The University of Melbourne to conduct a statistical review of the draft report prepared on the statistical projections based on 2009-2010 and 2010-2011 child protection reports.

The report prepared by the Statistical Consulting Centre confirmed that the up-dated projections followed the general principles of the 2003 projections and noted that the increase in the forecast percentage of children who will be subject of a child protection is a direct consequence of the increase in child protection reports. The Statistical Consulting Centre also noted it was not in a position to assess the quality of the data on first time reports and the assumptions underlying the population projections.

Appendix 6: Legislative framework applying to children in a protective or criminal context in Victoria

Table 1 International instruments to which Australia is a signatory

Instrument	Key themes/provisions	Comment
Universal Declaration of Human Rights 1948	Art. 16(3) – the family is the natural group unit of society. Art. 25(2) – motherhood and childhood are entitled to special care and assistance and all children shall enjoy the same social protection.	These international instruments confer many similar general rights to children as they do to adults (such as the right to life, freedom from torture, cruel inhuman or degrading treatment, right to health and health services and right to education). The Convention on the Rights of the Child restates some of these rights in a child specific instrument.
Convention on the Rights of the Child 1989	Art. 3 – In all actions concerning children by private or public bodies the best interests of the child shall be a primary consideration. Art. 9 – A child should not be separated from his/her parents against their will except when determined by competent authorities, subject to judicial review and in accordance with law, it is in the best interests of the child. In any proceedings particularly where the case involves child abuse or neglect all parties should be given an opportunity to participate and make their views known. States shall respect the right of a child that is separated from one or both parents to maintain a relationship with their parent(s) on a regular basis except where it is contrary to the child's best interests. Art. 12 – Children, where capable of forming views, have the right to express his or her views and those views be given due weight taking into account age and maturity of the child. A child should be provided the opportunity to participate in any judicial or administrative proceedings affecting the child either directly or through a representative or an appropriate body. Art. 34 – Children should be protected from all forms of sexual exploitation and abuse (including unlawful sexual activity, prostitution and pornography).	

Table 1 International instruments to which Australia is a signatory (continued)

Instrument	Key themes/provisions	Comment
International Covenant on Civil and Political Rights 1966	Art.24 – Every child shall have without any discrimination the right to such measures of protection as are required by the child's status as a minor, on the part of the child's family, society and the State.	
International Covenant on Economic Social and Cultural Rights 1966	Art.10 - Protection and assistance should be accorded to the family. Special measures should be taken on behalf of children, without discrimination. Children and youth should be protected from economic exploitation. Their employment in dangerous or harmful work should be prohibited. There should be age limits below which child labour should be prohibited.	

Table 2 Commonwealth legislation

Act	Key themes/provisions	Comment
Commonwealth of Australia Constitution Act 1900	s.51 - Commonwealth Parliament may make laws with respect to marriage, divorce and matrimonial causes, parental rights, custody and guardianship of infants, and on any matter referred to it by a State Parliament with respect to that State.	The foundational document for system of government and federal-state relations in Australia. The State holds residual power to make laws with respect to child protection, education, care and adoption.
Classification (Publications Films and Computer Games) Act 1995	s.29 – The Classification Board must refuse to approve advertisements that depicts a person who is, or appears to be under 18 years of age in a way that is likely to cause offence to a reasonable adult regardless of whether the person is engaged in sexual activity or not.	
Child Support (Assessment) Act 1989	s.3 – Parents have the primary duty to maintain a child.	This Act concerns the provision of financial support to children.

Table 2 Commonwealth legislation (continued)

Act	Key themes/provisions	Comment
Crimes Act 1914	ss.10M and 10N – Child under age of 10 cannot be liable for an offence against a Commonwealth law and child between 10 and 14 can be liable but only if the child knows the conduct was wrong – burden of proof is on the prosecution. Part IAD (ss.15YA-15YT) deal with the protection of children in providing evidence in proceedings for sexual offences including rules for cross examination of child witnesses, provision of closed-circuit television facilities for the giving of evidence (and other means of restricting direct contact with a defendant), the exclusion of some or all members of the public from a court room if a child is giving evidence and making it an offence to publish material that identifies or leads to identification of a child complainant or witness without the leave of the court. A Judge must not give a warning or suggest to a jury that the law regards children as an unreliable class of evidence. Part ID (s.23XU, XWU, WE, WT etc) deal with carrying out of forensic procedures on a child. A child cannot consent to a forensic procedure. A child that is a suspect is entitled to have an interview friend or legal representative present during the carrying out of a forensic procedure. A Magistrate can order that a forensic procedure be carried out on a child (who is not a suspect) where a parent/guardian unreasonably refuses consent to the procedure or where their consent cannot be obtained but must consider whether the procedure is justified in all the circumstances and in the best interests of the child. A procedure is not allowed if the child objects to or resists the procedure regardless of that an order has been made.	
Criminal Code Act 1995	Part 2.3, Div 7 – Lack of capacity for children under 10 years or limited capacity between 10 and 14 years. Chapter 8, Div 268.7 – Genocide by forcibly transferring children and 268.68 – War crime for using, conscripting or enlisting children. Div 271.4 – Trafficking in children, and 271.7 – Domestic trafficking in children. Div 272 – Child sex offences outside Australia Div 273 – Offences for child abuse material or child pornography material offences outside Australia	

Act	Key themes/provisions	Comment
Family Law Act 1975	s.43 – Principles to be applied by courts exercising family law jurisdiction include giving the widest possible protection and assistance to the family as the natural and fundamental group unit of society, particularly while it is responsible for the care and education of dependent children and protecting the rights of children and to promote their welfare. Part VII – Deals with children in family proceedings. This includes the guiding principle that in making parenting orders, the best interests of the child are paramount (s.60CA) and principles for determining what are in the best interests of the child (s.60CC) and consideration of risk of family violence (s.60CG). There is an obligation on certain Family Court personnel, family law practitioners and counsellors to report suspected child abuse to prescribed child protection authorities (s.67ZA). The court may order injunctions for the personal protection of a child who is subject of the proceeding and a breach of injunction can lead to the arrest of that person 9ss.68B and 68 C). Rules governing inconsistency between parenting orders or injunctions issued by the family court and a family violence order against a person, including obligation on the family court to notify the relevant police agency, child protection service and the court that issued the family violence order (Division 11). Principles and rules for the family court in conducting proceedings involving children including consideration of the needs of the child their welfare, to conduct proceedings in a way that safeguards the child from abuse, violence or neglect and to conduct proceedings with minimal formality and technicality. Also sets specific duties and powers on the court to ensure those principles are achieved - particularly in relation to the giving of evidence (Division 12A).	
Immigration (Guardianship of Children) Act 1946	s. 6 – The Minister (responsible for immigration) will be the guardian of a non-citizen child and will have the same rights, duties and liabilities as a natural guardian until the non-citizen child turns 18 or leaves Australian permanently. s.7 – The Minister may place a non-citizen child in the custody of a person who is willing to be a custodian and is a suitable person in the Minister's opinion.	This Act deals with guardianship of non-citizen children being children who have entered Australia with the intention of permanent residency and are not in the custody of a parent, or an intending adoptive parent or a relative over the age of 21.
Migration Act 1958	s.4AA – Minors will only be detained as a measure of last resort.	

Table 2 Commonwealth legislation (continued)

Act	Key themes/provisions	Comment
Family Law Legislation (Family Violence and Other Measures) Act 2011	This Act replaces the current definition of 'abuse' in the Family Law Act and defines abuse as: • an assault, including a sexual assault, of the child; or • a person (the first person) involving the child in a sexual activity with the first person or another person in which the child is used, directly or indirectly, as a sexual object by the first person or the other person, and where there is unequal power in the relationship between the child and the first; or • causing the child to suffer serious psychological harm including but not limited to when that harm is caused by the child being subjected to, or exposed to, family violence; or • serious neglect of the child. The Act also sets out various circumstances that constitute 'family violence' which it defines as violent, threatening or other behaviour that coerces a member of the family. These circumstances include either: • an assault; • a sexual assault or other sexually abusive behaviour; • repeated derogatory taunts; • intentionally damaging or destroying property; • intentionally causing death or injury to an animal; • unreasonably denying the family member the financial autonomy that he or she would otherwise have had; • unreasonably withholding financial support needed to meet the reasonable living expenses of the family member, or his or her child, at a time when the family member is entirely or predominantly dependent on the person for financial support; or • unlawfully depriving the family member, or any member of the family member's family, of his or her liberty. The Act also sets out when a child is exposed to family violence, with examples being seeing or hearing an assault, overhearing threats of death or personal injury, assisting a family member who has been the subject of an assault or cleaning up after damage has been caused to property. The Act places a duty on a party to a proceeding, and a discretionary ability for a non-party, to notify the court if a child is the subject of care arrangements under child welfare laws or is the subject of a notification or report to, or investigation by, a prescribed state agency where the report relates to abuse.	

Table 3 Victorian legislation

Act	Key themes/provisions	Comment
Charter of Human Rights and Responsibilities Act 2006	s.17 – Families are the fundamental group unit of society and are entitled to be protected and every child has the right, without discrimination, to such protection as is in his or her best interests and is needed by him or her by reason of being a child.z	
Adoption Act 1984	s. 9 – In administering the Act the welfare and interests of the child are paramount. s. 45 – Where a child is awaiting adoption and a person who has custody or guardianship of the child has given the Secretary an authority to exercise custody rights and if, for various specified reasons, that authority has ceased, the Secretary must deliver the child to the person who was entitled to custody or guardianship of the child. Where such a person cannot be found after reasonable enquiry, the Secretary must take the necessary steps to make a protection application under the *Children, Youth and Families Act 2005*. ss. 106 - 107 – Where there is a contested application for an adoption order a child is to be separately represented in court and the proceedings are to be closed to anyone who is not a party or their legal representatives (unless otherwise directed by the court). Applies in Victoria the Convention on Protection of Children and Co-operation In Respect of Intercountry Adoption (Schedule 1).	
Births, Deaths and Marriages Act 1996	Act deals with registration of the birth, the name (and change of name) and the death of a child.	
Children, Youth and Families Act 2005 (CYF Act)	• s. 10 – Sets out the best interest principles by which the Act must be administered, particularly that the best interests of the child must always be paramount and in doing so, be guided by the need to protect the child from harm, to protect the child's rights and promote his or her development. ss.12 - 14 – set out additional guiding principles, particularly in relation to Aboriginal children, their placement and maintenance of continuity of links with their community and their culture. • s. 20 – Sets out the role of the Ombudsman in relation to certain administrative actions taken by bodies such as a registered community service or a principal officer of an Aboriginal agency.	

Table 3 Victorian legislation (continued)

Act	Key themes/provisions	Comment
	• Part 3.3 deals with community services, while Part 3.4 deals with out-of-home carers. Part 3.2 deals with reporting concerns about the wellbeing of a child to DHS and the process for dealing with such reports. Chapter 4 deals with children in need of protection including nominating Victoria Police and DHS as protective interveners for the purposes of the Act, mandatory reporting obligations on certain professionals, the types of orders that a court can make in relation to children (in the family division of the Children's Court), establishing a therapeutic treatment board to advise on treatment of children displaying aggressive sexual behaviour and to provide for long-term guardianship power to the Secretary of DHS in certain circumstances for a child over 12 years of age. • Chapter 5 deals with children and the criminal law including the presumption a child under 10 years of age cannot commit an offence, the jurisdiction of the Criminal Division of the Children's Court, standard of proof for criminal matters (beyond reasonable doubt s.357), and sentencing principles (Part 5.3) and sentencing options. • Part 7 sets out the jurisdiction of and processes for hearing matters in the Children's Court, the restriction on publication of proceedings and identifying children/parties, and also establishes the Children's Court Liaison Office and the Children's Court Clinic.	
Child Wellbeing and Safety Act 2005	• Part 2 establishes principles for promoting the safety and wellbeing of children in Victoria particularly in the development and provision of services to children and families by government, government funded and community organisations (ss.4 and 5). • Part 4 establishes a Victorian Children's Council to provide independent and expert advice to the Minister for Community Services and the Premier on policies and services that enhance child safety and wellbeing (ss.9-11). • Part 5 establishes a government Children Services Co-ordination Board comprising Secretaries of various departments and the Chief Commissioner of Police to review annually and report to the Minister on outcomes of government action in relation to children particularly the most vulnerable in the community and to monitor administrative arrangements to support coordination of government action at local and regional levels (ss.13 - 15). Part 6 establishes an office of the Child Safety Commissioner to promote child safety and child-friendly policies and practices in Victoria. Specific powers of the Commissioner include: • to provide advice and recommendations to the Minister (at the Minister's request) about child safety issues (s.19) • to review and (annually) report on the administration of the Working With Children Act 2005 and to educate the community about the requirements of that Act (in consultation with the Secretary of Department of Justice) (ss.24 - 25) • to monitor and advise the Minister on provision of out of home care services, to promote the provision of those services and, when requested by the Minister, investigate and report on an out of home care service (s.29)	

Act	Key themes/provisions	Comment
	• conduct an inquiry into (and prepare a report of) a child death where at the time or within 12 months before the time of death the child was a child protection client (i.e. the subject of a report under the CYF Act) and the inquiry must relate to the provision of or failure to provide services to the child before his or her death (s.33). The Commissioner can also conduct an inquiry into (and prepare a report of) child safety arising from a particular child protection client's case (not involving death) where the Minister considers and recommends an inquiry would assist in the improvement of child protection services and enhancement of child safety (s.33A) • confers various duties and privileges for the provision of information to the Child Safety Commissioner in the conduct of inquiries.	
Children Services Act 1996	This Act regulates the provision of education services or care services (which are not provided in a protection context under the CYF Act to children under the age of 13.	
Classification (Publications, Films and Computer Games) (Enforcement) Act 1995	s. 57A – It is an indictable offence punishable by up to 10 years imprisonment to knowingly use an on-line service to publish or transmit objectionable material that is or looks like a minor engaged in sexual activity or depicted in an indecent sexual manner.	
Coroners Act 2008	The Coroner investigates a 'reportable death' connected to Victoria which can arise from a number of circumstances including: where the death is unnatural or unexpected or violent or to have resulted from an accident or injury; death of a person immediately before their death was placed in safe custody under CYF Act, custody or care of DHS under the CYF Act, the custody of police or legal custody of the Department of Justice. A 'reviewable death' involves the Coroner reviewing the death of a child (aged under 18) connected to Victoria provided that the child is the second or subsequent child of the deceased child's parents to have died or the child did not die in hospital after being born and being treated as an in-patient in that hospital (s.5). A medical practitioner who is present at, or after the death of a child is obliged to report the death of that child and a penalty applies for failure to report (s.13). The principal registrar of the court must report to the Consultative Council on Obstetric and Paediatric Mortality and Morbidity under the *Public Health and Wellbeing Act 2006* of the particulars of a death of a child reported to the Coroner (s.49). In conducting Coroner's investigations, the Coroner must be guided by the principles set out in the Act including: to avoid unnecessary duplications of investigations by liaising with other authorities and agencies; ensure the coronial system operates in a fair and efficient manner; keeping family members informed of progress of investigation (where appropriate); avoiding unnecessarily long or protracted investigations having regard to family, friend and community. There is a need to balance the public interest in protecting a living or deceased person's personal or health information with the public interest in the legitimate use of that information (ss.8 and 9).	

Table 3 Victorian legislation (continued)

Act	Key themes/provisions	Comment
Crimes Act 1958	The Acts sets out offences against or involving children and certain child related considerations for criminal investigation procedures. Defines 'violence' generally against a person and also in relation to a child as causing or allowing the child to see or hear the physical, sexual or psychological abuse of a person by a family member or putting the child or allowing the child to be put at real risk of seeing or hearing that abuse. Offences – child homicide (s.5A), infanticide (s.6), female genital mutilation (s.32), objectives and principles for rape and indecent assault type of offences include protecting children against sexual exploitation (ss.37A and 37B), incest (s.44), sexual penetration of a child under 16 years of age (s.45), indecent act with a child under 16 years (s.47), sexual penetration of a child under 16 or 17 years where the child is under the person's care, supervision or authority (s.48), facilitating sexual offences against children (s.49A), occupier/owner/manager of premises inducing or knowingly allow a child on the premises for purpose of taking part in an act of unlawful sexual penetration (s.54), abduction of a child under 16 for the purposes of that child taking part in an act of sexual penetration (s.56), procuring sexual penetration of a child (s.58), child stealing (s.63), child pornography (ss.67A-70AA), sexual (live) performances involving a minor (s.70AC). Procedure – Requirement to apply to the Children's Court for a child to be delivered into custody if an investigating officer reasonably believes the child of having committed an offence. The child must be present before the court and must have legal representation unless they refuse - the Court may order Victoria Legal Aid to provide legal assistance. The court can impose certain conditions in relation to the period of custody and requirements for interview (s.464B). Section 464K to 464M deal with restrictions and processes for fingerprinting children to 17 years of age. Section 464U deals with prohibition on undertaking forensic procedures on children under 10 years of age and restrictions on undertaking procedures where the child is between 10 and 18 years of age.	
Evidence Act 2008	ss. 5 and 8 – This Act does not affect the operation of provisions of other Acts (notes that provisions in other Acts, including the CYF Act, that relieve courts from applying the rules of evidence, are preserved). s. 18 – A child (among other specified relations) of an accused may object to give evidence as a witness for the prosecution and must not give evidence if the court finds there is a likelihood that harm is caused to the person or the relationship between the person and the accused and the nature and extent of the harm outweighs the desirability of giving evidence. s. 79(2) – It is an exception to the opinion rule where an opinion is expressed in relation to the development and behaviour of a child generally and/or the development and behaviour of children who have been the victims of sexual abuse, where that opinion is based on specialist knowledge of child development and child behaviour including knowledge of impact of sexual abuse on child development. See also section 108C which is a similar exception to the credibility rule).	

Act	Key themes/provisions	Comment
	ss. 165 and 165A – These provisions deal with warning a jury about unreliable evidence and the evidence given by children. A judge must not warn a jury that children as a class are unreliable witnesses or their evidence is inherently less credible or their age may impact on reliability. The judge may caution the jury about evidence given by a particular child and that it may be unreliable or about the weight to be given to that evidence (and the reasons why), if a party has satisfied the court that there are circumstances (other than the child's age) that affect that the reliability of that evidence.	
Family Violence Protection Act 2008	Preamble/principles – Parliament recognises that while anyone can commit family violence, family violence is committed predominantly by men against women, children and other vulnerable persons. Exposure to the effects of family violence can have a serious impact on children's current and future physical, psychological, and emotional wellbeing. s.5 – defines 'family violence'. s.24 – A police officer responding to an incident may apply to a senior officer (Sergeant or higher) for a family violence safety notice if, amongst others, the officer has no reasonable grounds for suspecting there is a family law order or child protection order in force that may be inconsistent with the proposed terms of the safety notice. s.36 – If a police officer serves a safety notice on a respondent that includes an exclusion condition, they must consider the accommodation needs of the respondent and any dependent children and take any reasonable steps to ensure the respondent and children have access to temporary accommodation. If the notice does not include an exclusion condition the police officer must consider the accommodation needs of the protected person and any dependent children and ensure they have access to temporary accommodation. s.45 – Application for a family violence order may be made, if the affected family member is a child, by the parent or any other person with the written consent of the parent or by leave of court, or where the child is above the age of 14, by the child with the leave of the court. However, the court must not grant leave unless it is satisfied that the child understands the nature and consequences of the order (s.46). s.47 – A court may include an application for an order for a child in the application for an order for an affected parent if it arises out of the same or similar circumstances. However it may be heard separately (on application by the applicant or by the respondent) if the court thinks fit. s.50 – Magistrate or registrar may issue an arrest warrant for the respondent on hearing an application and they believe on reasonable grounds it is necessary to, amongst others, protect a child who has been subjected to family violence. s.62 – If an affected member in the proceedings is a child, and the child is not the applicant or the respondent, the child may have legal representation only if the court, on its own initiative, considers it appropriate in all the circumstances. The court must consider in making that decision the desirability of protecting children from unnecessary exposure to the court system and the harm that could occur to the child or the child's family relationships if the child were to be directly represented.	

Table 3 Victorian legislation (continued)

Act	Key themes/provisions	Comment
	s.67 – A child who is not an applicant or a respondent must not give evidence in the proceeding unless the court gives leave and in doing so, the court must consider the two factors outlined in section 62 above. This applies despite anything to the contrary in the *Evidence Act 2008*. s.69 – The court may make alternative arrangements for conducting a proceeding (to protect an applicant or witness) as it considers appropriate and must do so if the witness is a child – unless it is more appropriate to do otherwise having regard to the wishes of the child, or their age/maturity, or the facilities available and any other matter the court considers appropriate. s.70 – sets out special rules for the cross-examination of a 'protected witnesses' of which children are a category. Part 4, Division 3A ss.73A – 73H – sets out the powers and processes for the Children's Court to order assessment reports be done by DHS of a protected person, an affected person, or the respondent. If the person is a child the court must not make an order unless that child is legally represented and in any case, consents to the making of the order. s.77 – A court, when making final orders, if satisfied on the balance of probabilities that any children who are family members of the affected family member or the respondent have been subject to, and are likely to be again subject to family violence, include that child/children as a protected person under the order made for the protected person or issue a separate final order with respect to that child. s.80 – In considering what conditions to attach to the intervention order, the court must give paramount consideration to the safety of any children who have been subjected to family violence to which the application relates (and if the order incudes excluding the respondent from the protected person's residence the court must consider amongst others the potential disruption to the child, potential loss of social networks and support, and maintaining continuity of care, education and childcare arrangements s.82). s.83 – If the respondent is a child the court may include an exclusion condition in the order if satisfied the child will have appropriate alternative accommodation, supervision and care. If the child is an Aboriginal or Torres Strait Islander, as a priority the court must have regard to the principle that the child should live with extended family or relatives and the need for the child's culture and identity to keep in contact with the child's community. ss.89 – 94 – These provisions deal with interaction between the family violence order and family law orders under the Family Law Act including considerations of the respondent's contact with of the child (including prohibiting all contact if it jeopardises either the child's safety or the protected person's safety). ss.145 -149 – These deal with the jurisdiction of the Magistrate's and Children's Courts to hear applications under the Act and when applications may be transferred from one court to the other. s.166 – This provision restricts subject to certain exceptions, the publication of proceedings where the matter is heard in the Magistrate's Court and a child is involved (where the matter is heard in the Children's Court then s.534 of the CYF Act applies).	

Act	Key themes/provisions	Comment
	ss.172 – 173 – Relationship with the CYF Act – In exercising jurisdiction under this Act, the Children's Court is not required to have regard to the principles set out in Part 1.2 of Chapter 1 of the CYF Act. A family violence order applies despite any child protection order but if the Children's Court is hearing an application for a child protection order and there is a family violence order in place in relation to that child, the court may on its own initiative revoke or vary the family violence order to the extent it is inconsistent with the proposed order to be made under the CYF Act. s.175 – If a person is arrested under warrant under s.50 of this Act and bail is granted subject to conditions, the bail conditions prevail over any child protection order to the extent of any inconsistency.	
Ombudsman Act 1973	Ombudsman has the power to investigate administrative actions of Victorian government departments and statutory bodies and to report to Parliament. Administrative actions' are defined by the Act to mean any action relating to a matter of administration, and includes a decision and an act; the refusal or failure to take a decision or to perform an act; the formulation of a proposal or intention; and the making of a recommendation including a recommendation made to a Minister (s.2). Ombudsman may either enquire into, or investigate, a matter on receipt of a complaint or on his/her 'own-motion' (ss.13A and 14).	The Ombudsman also has a power under the *Charter of Human Rights and Responsibilities Act 2006* to inquire into and investigate whether any administrative action is incompatible with the human rights set out in the Charter. Victorian Ombudsman's power does not extend to inquiring into matters of policy – *Booth v Dillon (No.1)* [1976] VR 291
Serious Sex Offenders (Detention and Supervision) Act 2009	This Act enables the ongoing detention or supervision of an adult who has served a custodial sentence for certain types of sexual offences and who presents an unacceptable risk of harm to the community. It also allows for the ongoing treatment and rehabilitation of the offender. s.12 – the court may issue a supervision order for a period not exceeding 15 years and s.15 – 17 allow the court to impose a range of conditions with that order.	

Table 3 Victorian legislation (continued)

Act	Key themes/provisions	Comment
	s.40 – the court may issue a detention order for a period not exceeding 3 years and s.42 specifies the effect of that order is detention in prison for that period. s.45 – The Director of Public Prosecutions to make an application for a renewed detention order and if the court deems an order appropriate section 47 specifies that the order commences on the date specified in the order and regardless of whether or not the existing order has expired. s.182 – It is an offence to publish proceedings under this Act that could identify the victim or any parties appearing before the court to give evidence (other than the offender) unless the court authorises publication. Police or media organisations may publish the identity or location of the offender for restricted law enforcement purposes. s.184 – Allows the court to order restrictions on publication of information that may identify the offender particularly their location if the court considers it in the public interest to do so (either on the application of the offender or on the court's own initiative). s.185 – In making that order the court must have regard to the whether publication would endanger the safety of any person, the interests of any victims of the offender or whether publication would enhance or compromise the objectives of this Act. Schedule 1 – Sets out the range of offences for which person may have been convicted and imprisoned that qualifies the offender for ongoing supervision or detention.	
Sex Offenders Registration Act 2004	s.6 – Defines a registrable offender and this extends to sex offenders who are registered under corresponding schemes outside Victoria. However exempts children who have been sentenced for committing registrable offences or who have not been convicted but the subject of other orders under the CYF Act. s.14 – Sets out initial reporting obligations of the offender to police including timelines for reporting and types of information to be reported including telephone number, physical address, email address, internet service provider details, vehicle details, employment details and details of children who may reside in the same household or who the offender may have regular unsupervised contact. s.16 – Imposes an annual reporting obligation on the offender. s.34 – Sets out the length of the reporting period of the offender depending on the class of offence of which the offender was convicted. This could extend to a life time reporting obligation. s.35 – Where the offender was a child at the time the offence was committed the reporting period is half of the time that would be imposed on an adult to a maximum of 7 ½ years (if the reporting period is life). Part 5 – Prohibits registered offenders from working in a wide range of child related services and imposes range of penalties for failure to comply with prohibitions. Schedules 1 - 4 lists four categories of offences which qualify convicted offenders to be registered on the SOR. Offences falling within Categories 1 and 2 involve offences against children leading to automatic registration. Offences in Categories 3 and 4 involve conviction for offences against adults that may lead to registration or reporting obligations under the Act.	

Act	Key themes/provisions	Comment
Stalking Intervention Orders Act 2008	There is one ground for issuing an order and that is if a person is found to be 'stalking' another person. Stalking encompasses a range of activities under s.4 of the Act including following someone, contacting them by other means, keeping a person under surveillance, tracing their emails and other electronic communications. s.6 – Family Division of Children's Court given jurisdiction if the respondent (stalker) or the affected person is under 18 and it is appropriate for the matter to be heard in that court. s.9 – Before making an intervention order the court must take into account the welfare of any children affected by the order (but noting that paramount consideration is to be given to the affected person). s.20 – Rules of evidence (excepting Part 3.10 of the *Evidence Act* 2008) need not apply to a hearing where the affected person is a child. s.49 – It is an offence to publish any information, including photographs, of the proceeding, where the proceeding involves a child and the publication is calculated to lead to the identification of the child or any other person party to that proceeding. s.51 – An intervention order prevails over any order made under the CYF Act (but court is given the power to revoke or amend an intervention order to the extent it is inconsistent with an order a court may make in relation to child protection).	This Act will be replaced by the *Personal Safety Intervention Orders Act 2010* (proposed to commence by proclamation in late 2011 with a default commencement date of 1 January 2012). This new Act now introduces various discrete grounds for obtaining a personal safety intervention order (PSIO) beyond the now 'stretched' definition of stalking which is what the 2008 Act covers. In relation to children, this Act will now prohibit the issuing of PSIOs against children under the age of 10. If a child is between 10 and 18 years the court must consider the child's ability to understand the nature and effect of the order and whether it will be effective in relation to that child. The Bill includes the power given to the Children's Court under the CYF Act to order an assessment of the child (with their consent). It remains an offence to publish proceedings which involve a child. A PSIO prevails over any order made under the CYF Act (but court is given the power to revoke or amend a PSIO to the extent it is inconsistent with an order a court may make in relation to child protection).
Working With Children Act 2005	Act regulates the ability of adults to do paid or volunteer work that involves direct contact on a regular basis with children to protect children from sexual or physical harm. Registered sex offenders are prohibited from even applying for a working with children check assessment and other individuals found guilty of specified offences may be refused a working with children check.	

Appendix 7: Preventative services in Victoria

Victorian services and programs in Victoria that contribute to child wellbeing and the reduction of child abuse and neglect

Program	Funding source	Service coordination	Service delivery
Maternal and Child Health Service	Victorian and local government share 50 per cent each of total costs. In 2009-10, DEECD funded $28.1 million. (Local government contributions determined at local levels).	Victorian Government (DEECD) in conjunction with local governments through municipal early years plans.	Local government
Child care, principally long day care and family day care	Commonwealth Government	Victorian Government	Local government, non-government organisations, and for profit organisations
Four-year-old kindergarten	Victorian Government In 2010-11 DEECD paid approximately $165.8 million (where kindergarten is delivered in long-day care, the Commonwealth also contributes)	DEECD	63 per cent of kindergarten programs are run by CSOs, with the remainder provided by local councils and private sector operators.
Primary School Nursing Program	Victorian Government – DEECD $7.4 million in 2010-11	DEECD	DEECD - regions

Objectives	Effectiveness in meeting objectives
• Universal primary health service for all Victorian families with children from birth to school age. • Focused on promotion, prevention and early detection of physical, emotional or social factors affecting young children and their families, and intervention where appropriate. • First time parent groups aim 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 were 606,824 visits to MCH centres in 2009-10, up from 590,000 in 2008-09. • Almost all Victorian infants, 99.8 per cent in 2009-10, receive MCH checks at birth. • Participation in the service declines as children age, with only 63.1 per cent of families using the service at the last 3.5 year old check-up. • In 2009-10 there were 13,628 first time parent groups provided in 79 local government areas.
• The National Partnership Agreement on Early Childhood Education prescribes the objective that children have access to the support, care and education throughout early childhood that equips them for life and learning, delivered in a way that actively engages families and communities, and meets the workforce participation needs of parents.	• In 2010, 133,639 Victorian children under 6 years attended Australian Government approved child care services. • In 2010, 7.4 per cent of Victoria's residential population of children under one; 30.8 per cent of one year olds; 42.6 per cent of two year olds; 48.1 per cent of three year olds; 40.7 per cent of four year olds; and 24.1 per cent of five year olds attended Australian Government approved child care services. (The above percentages largely exclude children attending sessional kindergarten programs.)
• Kindergarten programs are universal services for children in the year before they start school, to help children to develop a range of skills including social, emotional, and cognitive skills. • The government contributes towards the cost of four-year-old kindergarten programs. The government also subsidises fees for families deemed 'financially disadvantaged' to cover the full cost of attending 10 hours of kindergarten per week.	• In 2010, 66,651 children attended kindergarten, up from 62,365 in 2009. • The current 95 per cent participation rate meets the nationally agreed target for universal access. • However, DEECD has not established who the non-participants are, and whether they include children and families most in need of service (Victorian Auditor-General's Office 2011b, p. 11) .
• The Primary School Nursing Program provides a free health care and referral service to all Victorian children attending government, independent and catholic primary schools. • The health check uses a questionnaire to identify children requiring a more comprehensive health and wellbeing assessment to support better health and learning outcomes.	• The program has not been formally evaluated. • The population data collated each year highlights that the nursing program is able to identify vulnerable children based on parent's perceptions of their child's health and wellbeing.

Victorian services and programs in Victoria that contribute to child wellbeing and the reduction of child abuse and neglect (continued)

Program	Funding source	Service coordination	Service delivery
Parenting services	Victorian Government – DEECD $4.6 million in 2010-11	DEECD	Parenting services are coordinated and delivered primarily by CSOs, with some delivery by local governments. Includes the Parentline, which is delivered and coordinated by DEECD.
Playgroup Victoria	Varied, some financial support provided through Victorian Government (DEECD) (see Chapter 9 for further information)	Community based	Some community based, some coordinated through
Antenatal care	Victorian Government Department of Health	Department of Health	Department of Health, health services
Primary health care – general practitioners (GPs)	Commonwealth Government through the Medicare Benefits Schedule	Commonwealth Department of Health and Ageing	GPs

Objectives	Effectiveness in meeting objectives
• Provides parenting support, information, education and advice to parents, as well as training and consultancy to professionals. • Designed to be accessible to all parents and provided wherever possible through universal service platforms.	• According to information provided by DEECD, over 95 per cent of parents recording satisfaction with the intervention.
• Promote attachment and build parenting capacity. • Prepare children for more formal learning institutions and environments. Act as soft entry points into the service support system, as well as platforms to maintain families involvement in family support and more intensive individual services. • Assist in building community relationships and capacity.	• Research based on the Longitudinal Study of Australia Children shows that boys and girls from disadvantaged families scored 3-4 per cent higher on learning competence at age 4-5 if they attended playgroup at age 0-1 and 2-3 years, when compared to children from disadvantaged families who did not attend playgroup (Hancock et al. in press, p. 2). • Demographic characteristics also showed that disadvantaged families were the families least likely to access playgroups.
• Access to antenatal care can have a significant impact on the health and wellbeing outcomes of mothers and babies by addressing modifiable risk factors for maternal and child health outcomes. • Women with low risk pregnancies attend seven to ten antenatal visits commencing in the first trimester.	• Of approximately 73,000 births per annum, around 70 per cent of these occur in public hospitals. • Specialist clinics exist for women identified as vulnerable, but requires a referral from a medical practitioner so some vulnerable women may not be accessing these services.
• GPs are the first point of contact for medical care and referral in Victoria. • The universality of GP services means that GPs have a unique ability to identify and assist vulnerable children, young people and families. GPs treat many parents with substance dependence issues and/or mental health problems, as well as family violence, so are well situated to consider the needs of children in such families	• As at June 2009 there were 1,645 general practices in Victoria with just over 6,000 GPs.

Appendix 8: Early intervention services in Victoria

Table 1 Programs available in range of jurisdictions with extensive evaluations

Cohort	Program/service
Antenatal/ Infants	**Nurse Home Visitation Program (NHVP)** Originating in the United States(US), NHVP was developed by David Olds. The program involves prenatal and early childhood home visits by nurses and was designed to help young first time mothers women take better care of themselves and their babies.
	South Australian Family Home Visiting (SAHV) program This program provides home visits by qualified child health nurses supported by multidisciplinary teams of psychologists, social workers, Aboriginal health workers and family brokers. All families receive one home visit within the first few weeks of the child's life. The model does not provide prenatal visiting. Families that are identified with additional needs may be offered ongoing home visits up to the child's second birthday. The program involves 34 visits focusing on child health and development and maternal-child attachment. The visits take place weekly for the first six weeks, then fortnightly for the next six months. Families receive monthly visits for the final 12 months of the program, and are supported in forming links with their local community (Sivak et al. 2008). To be offered the program, mothers and infants must meet at least one of the following eligibility criteria relating to the primary caregiver: they are less than 20 years old; they are socially isolated; they have been identified as having a poor relationship with their infant; they have a history of maternal mental health or substance abuse problems; or the child is identified as being of Aboriginal or Torres Strait Islander descent (Sawyer et al. 2010).
Pre-school	Perry Pre-school Perry Pre-school was an American preschool education program that combined intensive parent focused supports and high quality early childhood education and care for on children growing up in low income families.
	Sydney Day Nursery (SDN Children Services Inc) Based in Sydney's south-west, the centre provides a range of resources for families with young children aged birth to eight years. Services are hierarchically arranged. At the universal level, and open to all members of the community, the centre contributes a qualified early childhood education teacher to the staff of the existing children's Resource Centre (Toy Library). The Resource Centre aims to be accessible to as many families as possible by being responsive to the needs of families, flexible, affordable and inclusive. At the targeted level, the centre offers stay and play sessions (facilitated playgroups) where parents and carers focus on playing with children in a quality play environment, supported by the early childhood education teacher and a family resource worker. Also at the secondary level are parent groups, offered in partnership with Relationships Australia, that provide opportunities for parents to come together to focus on issues of concern or to access new information, in the company of staff with whom they have a relationship and can trust. At the highest level of intervention, individual family support delivered by a trans-disciplinary team offers intense, individualised, intervention for families with the wide range of challenges. The centre represents an integrated approach to service delivery; is responsive to local conditions; develops trusting relationships with other agencies; is "play" focused; is trans-disciplinary; and is grounded in theory and evidence of what works and is outcomes focused (Communities and Families Clearinghouse Australia 2011).

Available evidence

Extensive evaluation, with longitudinal studies commencing in 1977. Results showed mothers who were home visited throughout pregnancy smoked less, had heavier babies, suffered fewer kidney infections, and had fewer pre-term babies. Intervention mothers were more likely to return to school, three times more likely to be employed and three times more likely to delay future pregnancies (Watson et al. 2005).

Further studies concluded that the program of prenatal and early childhood home visitation by nurses could reduce the number of subsequent pregnancies, the use of welfare, child abuse and neglect, and criminal behaviour on the part of low-income, unmarried mothers for up to 15 years after the birth of the first child (Olds et al. 2010).

A qualitative evaluation of how the SAHV program was being received by Aboriginal mothers conducted by the Australian Centre for Child Protection, included findings from focus groups and interviews with Aboriginal family members, the vast majority of whom were enrolled in Family Home Visiting or who had graduated from the program. It also included information from focus groups with Indigenous cultural consultants. The evaluation of the program noted that participants identified a range of strengths provided by the program, namely: practical assistance; information and referrals for health and other issues; feeling more socially involved; and feeling more support and confident in parental decisions (Sivak et al. 2008, p. 7).

Note that further evaluations are being conducted, and are not available for consideration at this stage. The initial evaluation needs to be considered in light of this limitation.

This study is arguably the pre-eminent case for the economic benefits of early intervention. A 25-year study program has provided the basis for a cost-benefit analysis.

Findings indicate the program produced economic benefits to participants and to the general public that greatly exceeded the costs of the program. Barnett (1993) calculated that by the age of 27 years, for every dollar taxpayers spent on the preschool early intervention program, there has been a subsequent saving of over seven dollars in health, welfare, criminal justice and social security expenditure.

The centre was evaluated in 2008 to ask:

1. Does it contribute to children's growth and development?

   Answer: Observational data suggested children benefited from their involvement with materials, adults and other children.

2. Does it support families in building parenting skills, developing social networks, accessing local services and preparing to re-enter the workforce?

   Answer: Findings suggest the centre accommodated members' diverse needs and helped develop parenting skills.

3. Does it contribute to community capacity to support families in their parenting?

   Answer: The centre is well understood and regarded in the community, and well connected to range of services. However, there is a need for greater utilisation of connections (Wong & Cumming 2008).

Table 1 Programs available in range of jurisdictions with extensive evaluations (continued)

Cohort	Program/service
	Sure Start This community program began in the United Kingdom (UK) in 1998 with the objective of providing quality services for children under four years old and their parents in the nation's most deprived areas (Melhuish et al. 2010). The original idea for Sure Start came out of the 1998-2000 Comprehensive Spending Review, which found that existing services for children were failing those in greatest need. The context of this review was the British Government's commitment to end child poverty within 20 years (Katz & Valentine 2009). A range of programs were instigated under the Sure Start banner, with all programs being expected to provide: outreach and home visiting; support for families and parents; support for quality play, learning and child care experiences; primary and community health care and advice about child health and development; and support for people with special needs, including help getting access to specialised services.
	Abecedarian project, United States Children from low-income families received full-time, high-quality, intensive educational intervention in a child care setting from infancy through age five. Each child had an individualised prescription of educational activities. Educational activities consisted of 'games' incorporated into the child's day. Activities focused on social, emotional, and cognitive areas of development but gave particular emphasis to language. The children's parents also received intensive assistance.
	Brighter Futures, New South Wales **Community Services Early Intervention Program** This program is delivered through a cross-sectoral partnership between community services and non-government organisations. It specifically focuses on families who are at most risk of entering the child protection system. A child protection prevention program that is targeted at vulnerable families with children at risk of abuse and/or neglect. The program targeted pregnant women and families with children aged under nine years, who were experiencing certain vulnerabilities and required long-term support from a range of services. Families enter the program through one of three pathways: • A report or request for assistance to the Child Protection Helpline; • A referral to a lead agency by a community agency or individual; or • A referral from an Aboriginal Maternal Infant Health Strategy (AMIHS) service. *Brighter Futures* offered families intensive support through core services including case management, child care, parenting programs, and home visiting. Participant families received a range of services, with the majority of those interviewed valuing home visiting above all other services (Hilferty et al. 2010).

Available evidence

The findings from the National Evaluation of Sure Start (NESS) Team are mixed. The positive effects discerned applied primarily to the parents in terms of greater life satisfaction, engaging less harsh discipline, providing a less chaotic home environment and a more cognitively stimulating home environment. Children's health also benefited. The negative effects were that mothers experienced more symptoms of depression and parents were less likely to attend school meetings. The conclusion reached was that the results provide some support for the view that government effort to support children/families via the original area-based approach to Sure Start paid off, at least to some degree, even if some negative effects resulted as well (NESS Team 2010).

However, it is not clear that Sure Start reaches the most vulnerable of families and whether it prevents child abuse and neglect. Notably the Outcome Measures engaged by the NESS team did not include consideration of variation in child abuse and neglect. The objective of Sure Start was to enhance the life chances of young children growing up in disadvantaged neighbourhood (NESS Team 2010).

Each of the targeted neighbourhoods was funded over a 10 year period to develop services for families of pregnant women and children aged 0-4.

This project involved a study of the potential benefits of early childhood education for poor children and parental support. Four cohorts of individuals, born between 1972 and 1977, were randomly assigned as infants to either the early educational intervention group or the control group. Children's progress was monitored over time with follow-up studies conducted at ages 12, 15, and 21 (FPG Child Development Institute 2011).

Research on the program effects found that the experimental group children experienced durable gains in IQ, and achievement in mathematics and reading (Campbell & Ramey 1995).

Further studies on this program focused on whether the expenditure represented sound social investment, concluding that the program resulted in healthy returns for the investment of public resources targeted at a disadvantaged group (Masse & Barnett 2005).

The evaluation of *Brighter Futures* consisted of three components:

- **A results evaluation that aimed to determine if the program was meeting the needs and improving the outcomes for children and families who participated.**

Findings: Appeared to meet the needs and improved outcomes for the majority of participant families. The overall picture was of modestly improving family functioning; however, a substantial proportion of families didn't benefit. Children from families who completed the program and were managed by community services showed the most improvement, with decreases in risk of harm reports. Conversely, participant families with drug and alcohol problems and family violence showed the smallest reduction in reports. Children from families who successfully completed the program were less likely to go into out of home care than children from a comparison group of families that declined the program. Results showed a clear relationship between families' duration on the program and whether case plan goals were achieved. Most families stayed for shorter than the expected two years duration, but those that remained for relatively longer periods of time had better outcomes. Families who benefitted less included relatively more disadvantaged socially and economically, and were more likely to be Indigenous families, families with parental drug and alcohol problems or intellectual disability, families with children reported for neglect, and families with a long reporting history.

- **A process evaluation that aimed to determine if the program's administration and implementation was efficient and effective.**

Findings were generally positive. Overall it was implemented well, with improvement in organisational systems and partnership delivery over time. Staff on the ground were supportive of the program and the positive impact that they witnessed in families lives. It improved the morale of community services' staff, who enjoyed working with families in a holistic fashion. It also improved the Community Services image in the community and with individual service users. However, inefficiencies were also highlighted, suggesting necessary modification.

Table 1 Programs available in range of jurisdictions with extensive evaluations (continued)

Cohort	Program/service

Table 2 Enhanced universal services available in Victoria

Note: This table is not an exhaustive list of all programs currently available in Victoria.

Cohort	Program/service
Antenatal/ infants	**Enhanced Maternal and Child Health (EMCH)** EMCH provides support to disadvantaged children and families, in addition to the universal MCH. The service targets vulnerable families identified as having additional needs, including Aboriginal families; those with a parent with a disability and mothers with identified risk factors, with an emphasis on families with children up to 12 months of age. Frameworks to identify and respond to risk of family violence, SIDS factors and maternal mental ill-health are included. The service is managed and delivered by local government in community settings or by other locally based community services.
	Healthy Mothers, Healthy Babies program Program designed to support disadvantaged or vulnerable pregnant women to access services and improve their health behaviours through the antenatal and perinatal stages. The program targets women who experience barriers to accessing antenatal care services or who require additional support in pregnancy. It incorporates both a community based and home visits approach. 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. Following birth the worker ensures the woman is linked to MCH and other relevant service providers, with program discharge intended at around six weeks (HDG Consulting Group 2011).
	Koori Maternity Services (KMS) program Provides culturally appropriate maternity care and support for Aboriginal and Torres Strait Islander women. The principal focus of the program is on increased access to antenatal care, postnatal support and hospital liaison as a means of improving health and wellbeing for Aboriginal women and babies. All sites employ an Aboriginal health worker. Advocacy and facilitation of relationships with the birth hospital are important components of KMS.

Available evidence
• **An economic evaluation that aimed to establish if the program offered value for money for government.** This evaluation was restricted to families that exited the program having successfully achieved their goals. *Brighter Futures* was cost effective with the benefits outweighing program costs for this group. The longer-term benefits also outweighed the program costs for these families, and is estimated to provide savings for a number of government agencies. The cost benefit findings were limited to only four domains: education and the subsequent impact on labour force participation and wages; crime and justice; health and health care; and community services. The cost-benefit analysis therefore provides a conservative estimate of program benefits, as it does not consider the impact of *Brighter Futures* on child and family wellbeing (Hilferty et al. 2010).

Available evidence	Scope and cost
A literature review for EMCH has been conducted for DEECD in 2011. However, no evaluation of the EMCH service has been completed.	In 2009-10 there were approximately 7000 families provided service at a cost of $8.7 million (Victorian Auditor-General's Office 2011b, p. 2). The cost of service is calculated to allow 15 hours per client in metropolitan areas and 17 hours per client in rural areas.
Evaluation conducted from July 2009 to July 2011 with the objectives to assess the impact and outcomes of the program, evaluate the effectiveness of the service model and provide recommendations for future service development. Findings were that the program successfully provided vulnerable women with support during pregnancy and assisted women to achieve improved health and psychosocial outcomes.	Program is delivered by six community health agencies in eight locations covering eight LGAs in metropolitan Melbourne. Program received near 700 referrals for the two year evaluation period. Program was funded in 2008-09 State Budget with an allocation of $8.3 million over four years.
Not evaluated to date.	2009-10: 260 births for women using KMS. 2010-11: 350 births for women using KMS. Operates at 12 sites throughout Victoria. Funding of $1.9 million for 2010-11. Additional funding of $250,000 p.a. is provided to strengthen the network of programs available to support vulnerable Aboriginal children and families in areas of high levels of substantiation of child abuse in the 0-12 months age group. This is in Darebin, Greater Bendigo and Mildura. Additional $3.85 million over five years from 2009 for three services to provide additional midwife led antenatal and post natal care and one new service established.

Table 2 Enhanced universal services available in Victoria (continued)

Cohort	Program/service
	Early Parenting Centres (EPCs) There are three DHS funded EPCs currently operating in Victoria: Mercy Health O'Connell Family Centre; Queen Elizabeth Centre and Tweddle Child and Family Health Service providing a range of programs in both secondary and tertiary services. In recent years EPCs have adopted a model of care specialising in assessing and building parenting skills and competence in order to prevent problems facing families escalating. Their secondary support services have increasingly become more targeted to vulnerable children and their families through prevention and earlier intervention practices.
	Enhanced Best Start DEECD-funded initiative to support families, caregivers and communities to provide the best possible environment, experience and care for young children from pregnancy to school. Supports communities, parents and service providers to improve universal early years services so they are responsive to local needs, with strong emphasis on prevention and early intervention.
Pre-school	**Early Start Kindergarten (ESK)** This initiative is directed at children known to statutory child protection and Aboriginal children to increase vulnerable children's participation in three year old kindergarten. It provides a free kindergarten program for three-year-old children known to statutory child protection. ESK was piloted in 16 LGAs, with partnerships between the participating kindergartens, local family services and child protection.

Available evidence	Scope and cost
An evaluation of the Parenting Assessment and Skills Development (PASDs) Program was conducted by DHS in 2009. PASDs are largely provided by EPCs, but are a tertiary service and not relevant to this table. The Inquiry is not aware of any general evaluation of the early intervention services provided by the EPCs. The final Action Learning Project Report for the QEC Tummies to Toddlers Program is considered in Table 3 below.	EPCs provide a range of day stay, residential, group and home-based services to more than 3,000 vulnerable families from pregnancy to when a child is four years old. All EPCs deliver some services regionally. There is coverage across the state for some programs, but the level of service in rural areas varies. Total of $14,386 million funded by the state government for all programs for 2009-2010.
The University of Melbourne provided an evaluation of Best Start in 2006 (The University of Melbourne 2006). The evaluation found that Best Start had embraced opportunities to work in partnership locally across the early childhood sector. Early positive effects of projects were identified for breastfeeding and MCH attendance and there were some perceived increases in physical activity, literacy and child-friendly communities. The evaluation emphasised the importance of successful partnership between government and communities. The evaluation concluded that it was difficult for projects to successfully improve access to vulnerable groups, noting that for vulnerable families practices needed to be flexible, add value, involve service co-operation, require additional funding and focus on personal connections with families. Site selection was also an important variant to potential success of projects (The University of Melbourne 2006, p. 234). There has not been an evaluation of Enhanced Best Start to date. However KPMG has been contracted to undertake an evaluation of Best Start and this includes Enhanced Best Start. The final report is due in November 2012 with a supplementary report on Enhanced Best Start in March 2013.	There are 30 Best Start projects across the state. Two enhanced Best Start projects (Mildura and Shepparton) have been funded to trial some initiatives to improve outcomes for more vulnerable children, including those known to statutory child protection. Each Best Start site receives $100,000 recurrently, giving a total cost of $3 million per annum plus indexation. Enhanced Best Start sites receives an additional $200,000 per annum for 2011-12, 2012-13 and 2013-14 for the enhanced component.
DEECD commissioned Monash in 2010 to evaluate the roll out and implementation of ESK. Key findings of the evaluation indicated that: • Take up of ESK for children known to child protection had been low since its inception; • Little difference in numbers enrolled in ESK in participating LGAs compared with areas where no partnerships existed, therefore recommendation made to discontinue the partnerships;	Low enrolments for children known to statutory child protection: 2009-34 2010-209 Enrolments for Aboriginal children 2008-108 2009-238 2010-259 The program cost $920,000 in 2009-2010.

Table 2 Enhanced universal services available in Victoria (continued)

Cohort	Program/service
	Supported Playgroups and Parent Group Initiative (SPPI) This program aims to engage vulnerable/disadvantaged families and provide quality play opportunities for children at a critical time in their development. The playgroups are intended to build parents' capacity to support their child's health, development, learning and wellbeing and aims to increase families participation and linkages with other early years services and supports. Unlike community playgroups that are parent led, these playgroups are initiated and led by a paid coordinator -facilitator.
	Take a Break occasional child care program Take a Break provided respite for parents/guardians of children aged up to six years. The initiative was created to give parents and caregivers a break while their children learn to socialise.
Primary school age	**The Primary School Nursing Program (PSNP)** Provides a free health care and referral service to all Victorian children attending government, independent and catholic primary schools. The health check uses a questionnaire to identify children requiring a more comprehensive health and wellbeing assessment to support better health and learning outcomes. Primary school nurses primarily use the SEHQ as a 'triage tool' to assist in the identification of health and wellbeing issues that may impact children's health, development and learning. The recommended courses of action by nurses for children with identified needs may include: Low priority children • A letter to the parent/carer acknowledging their return of the questionnaire and advising that no further action is planned. Medium to high priority children • Contact with parent/carers by phone to discuss issues; and/or • Physical child health assessment conducted during the nurse's visit to the school.

Available evidence	Scope and cost
• Systematic barriers to access were identified including limited referrals from statutory child protection and family services, shortage of programs for three years olds in areas of need with degree qualified staff and difficulties of services in engaging families.	
While the literature to date is promising, there is limited empirical Australian research specifically on playgroups (Dadich & Spooner 2008, p. 97). The SPPI initiative has not been subject to a published evaluation.	Four population groups are specifically targeted: Aboriginal children and their families; CALD children and their families, with particular focus on recently arrived families; disadvantaged families with complex needs; and children and families affected by a disability. SPPI is state government funded and operating in 29 LGAs where Best Start operates. There are 153 supported play groups operating and 1,349 families and 1,847 children attending. The budget for SPPI is around $2 million per annum. This includes funding to 29 LGA's and funding to the Post and Antenatal Depression Association (PANDA) and Playgroup Victoria.
In 2010 KPMG undertook a review of the occasional child care funding model to look at options for the sustainable funding. The review found inefficiencies in the way the Take a Break program was operating, it was poorly targeted and not distributed equitably.	Commonwealth funding ceased in June 2010. The state government fully funded the program in 2010-2011 at a cost of $1.97 million, pending the outcome of the KPMG review. The program lapsed at the end of the 2010-11 financial year.
Has not been formally evaluated, but incremental changes over time to incorporate evidence based approaches to identifying children with potential health related learning difficulties and respond to parent's concerns and observations about their child's health and wellbeing, collected through the School Entrant Health Questionnaire (SEHQ). SEHQ was evaluated in 2010 which identified elements of process that reflected good practice. It commended the process for prioritising disadvantaged schools in terms 1 and 2. Population data collated highlights that the PSNP identifies children's vulnerability based on parent's perception of their child's health and wellbeing. In 2010, 85 per cent of SEHQ were returned for assessment: with 90.8 per cent from all Catholic schools, 88.2 per cent from all government schools and 81.8 per cent from participating independent schools. Approximately 90 primary schools do not participate in the program. The provision of service by the program was 70 per cent to Government schools, 23 per cent to Catholic schools and 6 per cent independent schools.	The program cost $7.4 million for 2011-12. Regions are provided with a budget, based on historical calculations. Regions then employ nurses and they are 'rostered' to schools to undertake Prep assessments and respond to referrals from schools for assessment for children from Grades 1 to 6. Central office is provided with two EFT. The program is offered to all children attending government, Catholic and independent primary schools in Victoria.

Table 2 Enhanced universal services available in Victoria (continued)

Cohort	Program/service
	The latter two actions may lead to referral to another health or community service to provide further assessment and/or ongoing support. Following a referral, nurses follow up with families to determine the outcome of the referral and provide subsequent advice to schools regarding any issues that may impact on classroom management. Nurses may provide additional follow up advice/support to families should they have difficulty progressing the referral recommendation. However, ongoing case management is not provided because the aim of the program is for children identified for further assessment and support to be under the care of a relevant service. Referrals to the school nurse may also be made by parents and teachers who have a concern about a child in Years 1-6 or for any child who is newly arrived from overseas. Nurses refer back to the assessment of the SEHQ when responding to a referral relating to a child in Years 1-6. The SEHQ also provides population based data about the health, development, learning and the wellbeing of young children that can be used for measuring population outcomes over time and for planning and policy development. In particular it can be utilised to inform planning and targeting of service delivery at a school, LGA and departmental regional level.
	The Primary Welfare Officer (PWO) 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. PWOs assist schools to promote the resilience of children and their engagement in school.
Secondary school age	**Nurses in secondary schools** School nurses provide health promotion and wellbeing information to secondary school students enrolled in targeted high need government schools. Approximately half the nurses have been allocated to schools in rural Victoria, resulting in 7 per cent of rural students having access to a nurse.
	School Focused Youth Service A statewide program that aims to develop strategies to prevent and minimise suicide risk factors in young people. It facilitates partnerships between schools and local community service organisations. It has a focus on prevention and early intervention.

Available evidence	Scope and cost
Collated 2010 data identifies that in growth corridors there is a higher than state average percentage of children whose parents expressed concern about their child's general development and behaviour. This collated population data gathered from the SEHQ has improved the capacity of the program to highlight the vulnerability of Prep aged children with greater specificity to provide opportunities for future planning.	
Evaluations of the PWO 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 had a positive impact on individual students, including by raising self-esteem and reducing incidences of aggressive behaviour (DEECD 2007b, p. 3).	The government has recently expanded the PWO initiative to provide an additional 150 PWOs over the next three years. In all, 56 schools will receive PWO funding for the first time in 2012 and 569 schools will receive it in 2012. These will be followed by approximately 87 schools in 2013 and 148 schools in 2014.
An external review of the program was undertaken in 2008. The review found that the program was highly valued by young people and the school community for the contribution it makes to the health and wellbeing of students in vulnerable schools. Specifically the review found: nurses are well regarded by students and staff; nurses are reasonably well integrated into school structures; students identified the importance of the nurse in providing an independent and impartial adult to whom they can talk in confidence; nurses are planning and delivering health promotion activities that align with state government adolescent health priorities	DEECD directly employs 100 EFT nurses and managers that work across two-thirds of government schools. Most nurses are allocated to two schools, two days per week. In all,198 schools are targeted across the state.
The program has not been evaluated.	In 2009-2010, 31,611 young people received a service. In 2010-2011, 45,147 young people received a service. The budget is $7.59 million for 2011-12.

Table 2 Enhanced universal services available in Victoria (continued)

Cohort	Program/service
	Student welfare coordinators Coordinators are responsible for helping secondary students handle issues such as truancy, bullying, drug use and depression. Student Welfare Coordinators work with other welfare professionals and agencies to address student needs.
	Student Support Services program This program aims to support children and young people in 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, visiting teachers and other allied health professionals. The primary reasons for referral to the program are concerns around: • Speech and language 26 per cent; • Social/emotional 20 per cent; • Curriculum/learning 20 per cent; • Behaviour 17 per cent; • Developmental delay 6 per cent; and • Other 11 per cent In most cases, services involve the student and the professionals; other family members are involved in 14 per cent of the services provided, mostly by psychologists but also by speech pathologists or social workers. The program has a strong focus on facilitating, building and strengthening partnerships with other support agencies – such as: early childhood services; community organisations; and health, family, child mental health and youth services – to provide increased options and coordinated service provision for families and their children.
All age groups	**Child FIRST and family services** This is the coordinated intake and service system for family services to support vulnerable children, young people and their families. It prioritises those with greatest need.

Available evidence	Scope and cost
The program has not been evaluated.	Funds available to all secondary schools to employ a student welfare coordinator, with a program budget of $12 million per annum. Funds are available to all government secondary schools and are allocated according to student enrolment. Student Family Occupation (SFO) is not included in the calculation. In all $12 million is invested across 320 secondary schools and P-12 schools. The average investment is $37,500 per school, which is roughly equivalent to 0.5 EFT per school. Small schools may get around 0.2 EFT. The exact number of student welfare coordinators is not known. In most cases they 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 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).	Available to students with additional needs in all schools across Victoria, all student may access the program but current numbers accessing service are not available. The budget for this program is $64.5million per year.
Interim KPMG evaluation – suggests a range of challenges with the Child FIRST model but ultimately considers the program is having a reasonable moderating effect on the demand for DHS statutory child protection services.	Provided service to 26,461 cases at a cost of $24.23 million in 2010-11.

Table 3 Locally delivered early intervention programs in Victoria

Note: This table is not an exhaustive list of all localised projects in Victoria.

Cohort	Program/service
Antenatal/ infants	**Starting Out** Starting Out is a community based support program provided by Connections for young, pregnant and parenting women up to the age of 25 years, their children and partners. It provides a range of services to improve young families' health and social outcomes including: • Pregnancy counselling and information about all of the options available including: becoming a parent, abortion and adoption; • Counselling about problems such as relationship difficulties, family conflict, parenting problems or stress; • Pregnancy and birth education and support; • Support and information from young parents who have had additional training as peer support workers; • Outreach support to develop skills in parenting and practical living; • Information, assistance and referral to other services including health, legal, financial, child care, employment and education; • Support for families in transitional housing; and • Playgroups where young parents and their children can meet, play and learn in a supported environment.
	Tummies to Toddlers An antenatal program offered by Queen Elizabeth Centre (QEC) that engaged and offered intensive care for highly vulnerable and at-risk women during their third trimester of pregnancy. The care and learning continues one-on-one in a home setting, as well as involving each family in a group setting for a period of two years. As noted by QEC in their submission to the Inquiry by reaching and engaging 'at risk' families for a longer period of time when considered in terms of cost effectiveness, it means that for every dollar spent now, there is a corresponding saving of $17 across social services, juvenile justice, the welfare system and the cost to the broader community (QEC submission).

Available evidence	Scope and Cost
The Inquiry is not aware of any evaluation of this program.	Young people who can access the service live in the municipalities of Boroondara, Knox, Manningham, Maroondah, Monash, Whitehorse, and Yarra Ranges. The cost of this service is not known.
This program was internally evaluated with a small sample. There were some positive findings regarding the enhancement of participants' parenting skills and notably, none of the children were placed in out of home care while engaged in the program. The findings of this program are encouraging as to the success of an early intervention model that utilised the evidence obtained from the Olds Nurse Family Partnership. Caution is required in placing emphasis on the results as the sample size was small (14 families were engaged in the program). Outcomes included: increased knowledge of infant health care and engagement with health and community services; increased understanding of infant development and safety and knowledge of public health programs; strengthened parent-child relationships; decreased anxiety and stress levels in the participating mothers (however, an overall reduction in depression was not strongly indicated) : reduced social isolation and development of friendships within the group. All infants resided with one or both parents at the end of the program (some with support from extended family) (QEC 2011, p. 4).	Tummies to Toddlers operated during 2010 and 2011 and was a two year antenatal and post-natal pilot program. The program engaged with seventeen women presenting with multiple and complex risk factors, including a history of child abuse, family violence, mental health and/or drug and alcohol issues, physical and intellectual disabilities, lack of stable housing, severe financial hardship and other challenges. Fourteen mothers participated through most of the program (QEC 2011, p. 3).

Table 3 Locally delivered early intervention programs in Victoria (continued)

Cohort	Program/service
	Family Life's Community Bubs This was a three year pilot project, that trialled an intensive community centred support program for high-risk parents and infants. The pilot program commenced service delivery in August 2003 and formally concluded in June 2006. The program is now continuing on an ongoing basis. Based on a socio-ecological model, the program provides up to 12 months intervention for families of infants at-risk, which includes individual, group and community support. Over the period of intervention, clients move from intensive holistic support provided by a parent support worker to volunteer supported community participation. The model of intensive outreach aims to strengthen the individual, family and community resources, in order for the at-risk infant to thrive and develop safely in the care of his or her parents/caregivers (Flynn & Hewitt 2007).
Pre-school	**Access to Early Learning Initiative (AEL)** The model has been developed to address identified barriers to access, through assisting families to locate, enrol, and engage in an early childhood education and care program. The initiative is primarily focused on the engagement of three-year-old children who are either known to statutory child protection or Child FIRST; or whose families are receiving an enhanced MCH service. There are five interrelated service components to the model: • A key facilitation worker who will assist in matching eligible children with suitable places and making practical arrangements to support the child's commencement and engagement in the service; • Quality early childhood education and care with a skilled and qualified educator who is able to engage both the child and family in an inclusive and positive manner; • Family support services - linkages will be made between the family support worker, key facilitation worker and the teacher to ensure a holistic approach to the support offered; • Professional and practice development to create and refine competencies required to provide a high quality program for eligible children; and • Provision of flexible brokerage funding to support the child's participation in the service, for example, cost of transport or the gap in child care fees.

Available evidence	Scope and Cost
Monash University's, Department of Social Work evaluated the program. In developing measures of effectiveness the following factors were considered desired outcomes: • Families develop and maintain community connections; • Identified infants were living at home; • Reduced family risk factors and/or reduced impact of risk factors; • Identified infant assessed as being within range of normal development; • Evidence of bonding and attachment between infant and parent; • Evidence of family stability; and • Client achieving set goals. Evaluation: The program was shown to provide an effective early intervention program for the majority of participant families, who were identified, largely by primary care providers, as being at-risk. The program was beneficial in enabling participants to reach personal goals, establish stability, forming connections in their community and safely caring for their child who was initially deemed to be at-risk in the family home. Key features of the program that contributed to its effectiveness in engaging, retaining and working with families at-risk were identified as: • Localised service provision which enabled easy access to programs; • Targeted service provision that was holistic in nature; and • Home-based support; • The program being embedded in an agency that provides a range of other family oriented services such as family counselling that participants were able to utilise as necessary. • Links with a neighbourhood house that enabled participants to develop informal social supports; and to participate in education programs and local community networks (Flynn & Hewitt 2007, pp. 8-10).	Privately funded at an unknown cost. The program's target group are families living in the Bayside area of Melbourne, who have an infant aged 0 to 4 months, and who have been identified by health or welfare professionals as having significant risk issues, and for whom, without intensive support, a report to statutory child protection was possible. During the pilot phase, the program aimed to work with 12 families per year and thirty-six over the three year pilot (Flynn & Hewitt 2007).
An evaluation will seek to consider the evidence base of the AEL model in the context of the continuum of support provided by a range of existing service models including the Children's Protection Society model. The evaluation will consider: • How effectively the pilots have been able to meet the intended outcomes of the model; • The benefits and limitations (including cost benefits) of the model in the context of other initiatives aimed at increasing the participation of vulnerable children in universal programs; and • The potential for AEL to be replicated and/or scaled up for broader application.	This is a new service that commenced in three pilot sites in July 2011 and will conclude in December 2012. A fourth pilot is likely to commence in 2012. The pilots are located in rural, metro and outer metropolitan areas. The partnerships are led respectively by Children and Family Services Ballarat (CAFS), the City of Melbourne, and EACH (Eastern Access Health Service). Funding of $180,000 per annum is available to support 10 to 12 children in each pilot site.

Table 3 Locally delivered early intervention programs in Victoria (continued)

Cohort	Program/service
	Children's Protection Society (CPS) model for child care The pilot program targets at-risk children and their families and is designed to provide early child care and education services five days per week.
Primary school age	**Northern Suburbs Schools Hub Pilot Project (NSSHPP)** The project's objective is to provide early intervention support for vulnerable children and their families. The northern suburbs family services worker, employed by the lead agency, Bethany, is co-located in a community setting in Corio/ Norlane area and works one day per week at each of the schools involved with the project.
	FAST (Families and Schools Together) This is a non-profit agency that designs and distributes family strengthening and parent involvement programs to help kids succeed in school and in life. Though FAST was founded in the US, it brings together local support resources to build protective factors around kids (Families & Schools Together 2011). In Australia, FAST is a multi-family group program, designed for children aged 5-9 years of age, who are identified as being at-risk. Selected children are invited to attend the program together with their family members. The program runs for eight-weeks, and focuses on parent involvement processes with structured activities to strengthen family functioning and cohesion, build social connections and reduce social isolation. It aims to build resilience and protective factors in children. The *FAST* program targets the underlying causes of being at risk of educational failure, substance abuse, violence and delinquency. To run a FAST program, a community collaborative team is recruited, consisting of a minimum of four members who must have representation from the following partners: • A school; • A community based agency; • A drug and alcohol agency; and • A parent consumer liaison (preferably a FAST graduate) (Kids Matter 2011).

Available evidence	Scope and Cost
The program is based on the methodologies of the Carolina Abecedarian Project and Perry Pre-school Study models. It is to be included in the evaluation DEECD are implementing of early learning initiatives.	This program is conducted from the CPS child centre in Heidelberg. It is understood by the Inquiry that the cost per child of this program is approximately $31,000 per annum.
Bethany Community Support prepared an interim evaluation report in October 2011. The report notes that the project brief set out to: facilitate referral pathways between target primary schools in the northern suburbs, statutory child protection and family services; strengthen service coordination and improve communication between stakeholders while promoting early identification, assessment and response to reduce risk factors; and enhance positive health, safety and wellbeing for children (Bethany Community Support 2011, p. 4). Identified successes of the program: analysis of interviews with professionals across education, family services and statutory child protection indicated high level of satisfaction with the program including continued engagement of schools, positive feedback from schools, family services and DHS. Identified challenges of the program: a number of challenges were identified including the level of demand for family services exceeding the capacity to provide a service quickly; and in some areas direct service staff seemed to have little understanding of the project (Bethany Community Support 2011, p. 15).	This project is a collaboration with four primary schools, the Child and Family Services Alliance, DHS and the Corio and Norlane Neighbourhood Renewal Community Schools Project.
Developed in 1988,the program was designed around emerging research indicating partnerships between schools, communities and parents could prevent school-related performance and behavioral problems. FAST also incorporates knowledge from family stress, social support and prevention theory; clinical techniques used in child therapy, family therapy, group work, community development and organizing; as well as evidence-based, best practice findings from published social research journals that enhance positive parenting outcomes. The Inquiry is not aware of any evaluation of FAST in Victorian sites.	The fee for the three phases of the program is $5,500 (incl. GST). It includes a two day *FAST* team training and three site visits to support program implementation, and a post implementation one day review. Program manuals are $88 per unit, and standard program evaluation is $1,650 (incl. GST). Additional costs include interstate travel and accommodation where required. There are also additional costs associated with the community collaborative team and program costs that range between $10,000 and $15,000 depending on how communities access existing programs to re-position community resources (Kids Matter 2011).

Table 4 Drug and alcohol resources and treatment available in Victoria

Resource	Program/service
Telephone support services	**Family Drug Help/Helpline** Family Drug Help (FDH) and Family Drug Helpline, operated by the Self Help Addiction Resource Centre (SHARC). Turning Point Alcohol & Drug Centre is a Victorian Government funded service for people concerned about a friend or relative using alcohol or other drugs. FDH 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 other drugs and current available treatment options. The service operates 24 hours a day and answers approximately 6,000 calls from family members annually. FDH also run more than 20 support groups across Victoria for family members. The Victorian Government has committed $184,000 to deliver this program in 2011-12.
	Directline, operated by Turning Point Alcohol & Drug Centre Families and individuals with alcohol or drug problems or health and welfare professionals can contact Directline. Directline provides 24 hour, seven day counselling, support, information and referral to treatment services across Victoria.
Resources for alcohol and other drug workers	**Bouverie Centre Beacon Strategy** The Bouverie Centre, *Beacon Strategy* is a project providing staff training, clinical and implementation support to the alcohol and other drugs (AOD) sector to implement purposeful family inclusive practices.
	Parenting toolkit The *Parenting support toolkit* is a resource to help alcohol and other drug workers address the vital role that parenting plays in their clients' lives. The toolkit aims to help AOD workers to assist parents and provide better outcomes for them and the best care for their children. The toolkit can be used with all parents - whatever their social and cultural background or circumstances. It has been designed for AOD workers and for all levels of client contact - from minimal through to intensive client interactions, from services offering harm-reduction to abstinence-based programs. It is unknown whether this toolkit is used extensively in AOD services.
Parent focused alcohol and drug services	**Parent Support and Family counselling programs** AOD treatment services funded for parent support programs offer short-term therapeutic support groups facilitated by AOD professionals. The aim is to increase the capacity of the family to respond effectively to the person with problematic alcohol and drug misuse. Other alcohol and drug treatment services provide families parenting skills, coping strategies, routines and access to other support services including connection to mainstream family support agencies and services. Targets parents who have participated in an AOD withdrawal program or who are living in alcohol and drug supported accommodation. The Victorian Government has committed $800,000 to deliver this program in 2011-12.
	Counselling services Alcohol and drug treatment services funded for counselling, consultancy and continuing care provide a range of services and supports appropriate to the needs of individuals and families who have alcohol and drug use problems. Services may include assessment, treatment and consultancy, referral and ongoing case management and outreach. The Victorian Government has committed $30.4 million to deliver this program in 2011-12.

Resource	Program/service
	The Royal Women's Hospital Women's Alcohol and Drug Service Women's Alcohol and Drug Service (WADS) provides a state-wide service aimed at improving the health and wellbeing of pregnant women who use drugs and alcohol. WADS offer clinical care, professional education and training for health professionals and service providers, research and advocacy for women and their infants. In 2010, WADS provided services to 54 women, with DHS involvement in up to two-thirds of these families (The Royal Women's Hospital submission). The Victorian Government has committed $772,000 to deliver WADS In 2011-12.
	Moreland Hall Intensive Playgroup Moreland Hall has an intensive playgroup program funded by a philanthropic source. It provides an intensive support service for parents alongside a playgroup. The support for parents includes support to enable supervised access to take place and opportunistic support, treatment and referral service for parents. The playgroup has engaged with families who do not access universal services (such as MCH and kindergartens). This playgroup has also provided support, treatment and referral for children and parents.
Youth specific alcohol and drug services	**Youth Dual Diagnosis Service** The Youth Dual Diagnosis Service promotes an integrated approach to treatment delivered through specialist mental health and AOD services. This service provides direct care to clients, advice to services and cross-sector education and training. The Victorian Government has committed $1.86 million per annum to deliver this initiative.
	Homelessness Youth Dual Diagnosis Initiative Youth homelessness dual diagnosis clinicians are co-located within identified youth homelessness services. They provide direct clinical support to young people, specialist support to homelessness case managers, education training and secondary consultations. In the period 2009 to 2011-12, the Victorian Government has committed $1.36 million per annum to deliver this initiative.
	Alcohol and drug youth consultants (ADYC) Alcohol and drug youth consultants offer direct interventions, secondary consultation, training and capacity building approaches in responding to 'high risk' young people living in out of home care environments including secure welfare. The ADYC provides support to prisoners in police cells, young people residing in secure welfare facilities, adolescent community placements and residential facilities. ADYC also provide support child protection and residential staff involved in their care. The Victorian Government has committed $464,000 to deliver this support program in 2011-12.
	Linking Youth and Families Together Linking Youth and Families Together (LYFT) is designed to assist young people and families address difficult issues related to alcohol. The three year pilot program aims to reduce the harm to young people (aged 12- 21 years) resulting from alcohol abuse by providing specialist family therapy aimed at improving communication, strengthening the family and encouraging treatment, health and wellbeing options. An independent organisation, Caraniche, is conducting an action research evaluation of all aspects of the program that has to date demonstrated significant client outcomes. Anglicare Victoria operates this program from five locations in the Eastern, Southern and Gippsland Regions. In 2008, the Victorian Government committed $1.7 million to deliver this pilot project until 2011-12.

Table 4 Drug and alcohol resources and treatment available in Victoria (continued)

Resource	Program/service
	Koori alcohol and drug services The Department of Health continues to fund a range of initiatives for Aboriginal Victorians. Funded initiatives include Koori alcohol and drug resource centres and Koori alcohol and drug workers who provide AOD assessment, referral, prevention and support to Koori clients affected by alcohol or drugs and their families.
	The Mirabel Foundation Mirabel assists children 0-17 years who have been orphaned or abandoned due to parental illicit drug use and are now in the care of extended family (kinship care).
Alcohol and drug treatment residential services	**Odyssey House Victoria** Family residential rehabilitation based at Odyssey House Victoria that works to create a sustainable environment to support positive change for those whose lives are affected by drugs and alcohol. The family program operates within Odyssey's therapeutic community to provide extra support to parents overcoming their addiction while simultaneously looking after dependent children. The Victorian Government has committed $2.64 million to this service in 2011-12.
	Youth Support and Advocacy Service Residents at Birribi move through a three-staged program and can stay up to six months. Birribi adopts a holistic approach to working with residents. The program is highly structured and aims to provide a range of activities each day. These include: living skills, education, relapse prevention, personal awareness programs, sport, music, adventure activities and camps. Each young person works through the program at their own pace and has personal goals to achieve. Birribi, located on a 15 acre property at Eltham, accommodates up to 15 young people, aged between 15 and 20 years. The Victorian Government has committed $1.38 million to this service in 2011-12.
	Youth Alcohol and Drug residential, home based withdrawal and supported accommodation services AOD services targeting youth are offered across Victoria. Youth Residential withdrawal services are offered at Box Hill, Bendigo, Geelong, Ballarat, Fitzroy, Dandenong, Footscray and St Kilda. Youth home-based withdrawal is also offered in a number of localities across the state. The Victorian Government committed $8.8 million to this program in 2011-12. **Bunjilwarra, Koori Youth Alcohol and other Drugs Healing Service** A statewide residential rehabilitation service, the Koori Youth Alcohol and Drug Healing Service, has been operating since June 2007. It's designed to help recovery from substance abuse issues and reintegration with the community, within the context of a culturally appropriate healing model. The service model aims to provide a safe and secure environment where young people can participate in a range of culturally appropriate AOD interventions. The Department of Health has continued to manage the construction of a permanent Koori Youth Alcohol and Drug Healing Service. Bunjilwarra, the new permanent service , is managed by Ngwala Willumbong Co-operative Ltd . Located in Hastings on the Mornington Peninsula, this service is designed to help young Koori people aged between 15 to 20 years. The Victorian Government has committed to $2.05 million to this service in 2011-12.

Source: Information provided to the Inquiry by the Department of Health

Table 5 Mental health services: early intervention programs

Program	Program/service
Alfred Health Youth Early Intervention teams	Alfred Health is piloting a redesigned child and youth mental health service for people aged under 25 years. Alfred CYMHS has strengthened its intake system to improve access, doubled the number of single session family consultations, increased the numbers of young people with eating disorders being treated and established a Youth Early Intervention team, which provides or facilitates a range of services for young people where they are needed through outreach and collaboration with other agencies including an operational partnership with headspace Southern Melbourne. In the Alfred Health model, Youth Early Intervention teams work collaboratively with local health and social support services, including Commonwealth funded headspace services (where they exist), general practitioners, AOD services, employment agencies, schools, psychiatric disability rehabilitation and support services and housing and support services. As a result, Alfred Health has doubled the number of children and young people receiving assessment and treatment services (from 0.8 per cent of the under 25 age group to 1.7 per cent of the under 25 population). In addition, the number of young people referred to headspace Southern Melbourne tripled in 2010-11.
Child and Adolescent Area Mental Health Services (CAMHS) and Schools Early Action (CASEA)	The CASEA programs are directed at younger children and their families, with the objective of minimising distress and the negative impacts of behavioural problems and disorders on the lives of children and their families. These service developments provide an opportunity for CAMHS to work with their local schools to provide timely and evidence-based interventions for young children, their parents and teachers, that can address current issues with behaviour management, prevent any deterioration of behaviour in vulnerable students and promote health and wellbeing. The aim of this initiative is 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 within the CAMHS catchment area. This may include students with disabilities who are integrated into mainstream schooling. CASEA is an early intervention program that identifies young children in government and Catholic primary schools (Prep-Grade 3) with emerging disruptive behavioural disorders. It aims to: • Identify and provide treatment for children with emerging disruptive behavioural disorders in the early years of primary school; • Build ongoing primary school capacity to identify and support these children, and through their parents refer for treatment when required; • Develop the role of the Student Support Service Officer (SSSO) program in early identification and follow up support for the target group; and • Build the capacity of parents to understand, manage and support children with disruptive behavioural disorders. The Victorian Government has committed $3.8 million to the CASEA programs in 2011-12.
Families with a Parent with a Mental Illness (FaPMI).	In 2007, Victoria developed a state-wide FaPMI strategy that gives an overview of the prevalence and impacts of parental mental illness. This strategy highlights issues in the service system for which a strengthened and better coordinated response could be developed, and provides examples of ways in which department-funded programs could work together to improve outcomes for these families. A small number of FaPMI coordinators were appointed in this first phase.

Table 5 Mental health services: early intervention programs (continued)

Program	Program description
	In 2008-09 the FaPMI initiative was enhanced to target vulnerable families who were being supported by Child FIRST and who may have co-occurring drug and alcohol issues as well as parental mental illness. This initiative aims to reduce the impact of parental mental illness on all family members. The initiative recruited mental health clinicians to work across seven (three metropolitan and four rural) Child FIRST/family services and their local area mental health and drug and alcohol treatment services. Linking clinicians to both services enabled a better mutual understanding of service systems and associated referral pathways. The role of FaPMI co-ordinators is to: • Enhance the capacity of mental health services to be family focused, • Provide/facilitate consultations; • Advise on programs that assist families and children; • Provide cross-sector training on the impact of mental illness on families and children; • Promote and develop programs and partnerships to improve service responses; and • Support the review of practice policy and procedures. Specialist mental health services, clinical and psychiatric disability, rehabilitation and support services, have developed local support programs for parents, children and young people who are affected by parental mental illness. Brokerage funding is available to support families when funding may be required to engage them with other services and for the development and training for facilitation of peer support groups for parents, young people and children, including supported playgroups. 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. It is important to note that only half the adult mental health services are funding for a FaPMI coordinator position. The Victorian Government has committed $1.3 million in 2011-12 to this initiative.
Perinatal	The perinatal mental health system spans the care continuum from prevention/early intervention through to tertiary care. To identify mental health symptoms early, a mental health screening program is being implemented in both the antenatal period in maternity settings and in the postnatal period in MCH settings. If a woman is identified as having mental health symptoms through the screening program, then treatment and support can be provided early before the symptoms become more severe. In rural Victoria, treatment and support is provided by the Perinatal Emotional Health Program. This program is an early intervention program where women identified through maternity and MCH services are provided with treatment and support. The program is delivered through nine area mental health services across rural and regional Victoria and 16 FTE positions are employed through the service. The Victorian Government commits $2 million per annum to the program. Under the National Perinatal Depression Initiative (2008-2013), additional treatment and support options have been funded for Victorian women to access the program. These include: professional telephone counselling and care co-ordination through PANDA; and additional psychological services provided through Early Parenting Centres. The Victorian Government commits $0.5 million per annum to deliver these services.

Program	Program description
	There are three mother-baby units across metropolitan Melbourne which provide residential and outreach support to women with significant mental health issues. These units support the mother in her recovery and also support mother/infant attachment. There are currently 20 mother baby unit beds in Victoria that receive a total of approximately $6 million per annum from the Victorian Government. Planning is at early stages to develop a further 15 beds in regional locations.

Source: Information provided to the Inquiry by the Department of Health

Table 6 Housing support programs in Victoria

Program	Program description
The Housing Pathways initiative	Leaving Care Housing and Support Initiatives is a partnership between two DHS divisions, Housing and Community Building and Children, Youth and Families. It provides up to two years case work support to assist young people up to 21 years of age transitioning from state care. Young people are supported to obtain and maintain housing and assisted to access services. Leaving Care Housing and Support Initiatives have three program components: Leaving Care Housing and Support Initiative; Homelessness National Partnership Leaving Care Housing and Support Initiatives and Indigenous Leaving Care Housing and Support. Leaving Care Housing and Support Initiative (including Indigenous projects) are funded $950,000 annually. The *National Partnership Agreement on Homelessness* (NPAH) - Leaving Care Housing and Support Initiatives are funded at $3 million over four years to the end of June 2013.
Youth Foyers	A total of $30.1 million has been committed through the *Victorian Homelessness Action Plan* for the development and construction of three purpose built 40-unit Foyer models of housing and support for young people who are homeless or at risk of homelessness. The Foyer-like models will provide young people who are homeless or at risk of homelessness with stable accommodation and personal support services with an emphasis on engagement in employment, education and training. These models are being developed in partnership with Hanover Welfare Services and the Brotherhood of St Laurence.
Step Ahead and Ladder	This is a joint venture between DHS and the AFL providing young people with an integrated package of accommodation, living skills, case management and access to education, employment and training opportunities for young people aged 15-25 who are homeless or at risk of being homeless. DHS' contribution is $4 million over five years. Ladder is an integrated supportive housing service for young people who are homeless or at risk of homelessness. Based on the UK Foyer model, the program provides housing, support, employment, education and mentoring services for young people to help them develop independent living skills and community connections, and to move on to independent lives. Step Ahead provides a Foyer-like model to assist young people to make the transition to greater independence. It provides an integrated package of accommodation, living skills, casework and access to education, employment and training opportunities, with support linked to a range of other services.
Homeless Youth Dual Diagnosis services	The service provide early intervention and case management to young people with co-existing substance misuse and emerging mental health issues. A dual diagnosis clinician is employed in each region and located in a youth homelessness organisation to deliver early intervention case management to young people with AOD and emerging mental health issues, and secondary consultation. The Youth Dual Diagnosis clinician's primary role is direct service, however, another of their responsibilities is to increase sector capacity in regard to issues around dual diagnosis. This may occur through presentations, networking and secondary consultations. This initiative is delivered in partnership with the Department of Health. Funding is approximately $3.5 million over four years under the National Partnership on Homelessness.
Youth refuges	Youth refuges work with young people, aged 15-25 years, in housing crisis and provide a period of stabilisation and support with their social, emotional and practical needs. Youth refuges work with a young person towards a sustainable and well-matched exit by providing continuity of care and an approach that focuses on strengthening a young person's abilities and connections with community. Youth refuges address each individual's practical, psycho-social and health needs within the context of a case management model. Funding was approximately $9.4 million in 2009-10. There has since been an increase in funding of $13.75 million over four years through the Homelessness strategy.

Program	Program description
Youth transitional support services	These services provide a range of supports to young people aged 15-25 who are homeless or at risk of experiencing homelessness to assist them towards independence through an outreach based service response. Funding of approximately $12.5 million in 2009-10.
Youth transitional support services	These services provide a range of supports to young people aged 15-25 who are homeless or at risk of experiencing homelessness to assist them towards independence through an outreach based service response. Funding of approximately $12.5 million in 2009-10.
Homeless children's specialist support service	Provides specialised support and assistance to children accompanying families receiving services from specialist homelessness services, through three streams of service: assessment and case planning, Intensive case management and group work. The program also has some brokerage funds. The program operates in the North and West Metropolitan, Southern Metropolitan, Hume and Barwon-South West regions. Funded at $5 million over four years from 2009-10 to 2012-13.
Regional Children's Resource Program	The Children's Resource Program is a state-wide initiative which provides assistance to homelessness and family violence agencies in supporting children. The program aims to improve the support provided to children accompanying homeless families. One EFT is provided in every region to fund the position of a children's resource worker. The program focuses on secondary consultation, providing resources, information training and advocacy. The children's resource workers also administer brokerage in each region. Funding is approximately $1 million per annum.
Homeless Children's Brokerage Support Project	This program provides $20,000 brokerage funds per annum per region, administered by the children's resource worker in each region. The funds are to be used to enhance opportunities for children experiencing homelessness to engage and maintain their education (including early education services such as child care and kindergarten), reduce social isolation by enhancing access to a range of supports, social and recreational opportunities within their community; provide social and emotional growth opportunities for children; and provide opportunities to increase relational bonds between parents/carers and children. Funded at approximately $160,000 per annum.
Young Men's Program	This is an early intervention and prevention program that delivers long-term intensive case management to young men who have had multiple episodes of homelessness, have complex support issues and are at risk of becoming chronically homeless. Funded at $425,000 over two years to the end of June 2013.

Source: Information provided to the Inquiry by DHS

Appendix 9: Detailed description of statutory child protection services by phases

1. Current legislative and service framework

In relation to statutory child protection services, the Secretary of Department of Human Services (DHS) has ten 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 on-going 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 out-of-home care, 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, protection order and case closure phases. The activities that take place in each phase are described from section 10.2.1 onwards.

DHS employs about 1,200 child protection practitioners and services 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 (Practice Manual). The Practice Manual addresses a wide range of operational issues such as duty of care, confidentiality, supervision, children in specific circumstances, critical incidents and complaints management to name a few.

For each of these matters, a mixture of rules, standards, procedures, advisory notes and best practice information is issued to child protection practitioners under the following sub-headings:

- Relevant legislation;
- Standards and procedures;
- Considerations for good practice;
- Contacts for further procedural advice;
- Related policy documents and procedures; and
- Checklists of required standards.

In conjunction with instructions and supervision provided by managers and supervisors, the Practice Manual is a central tool used by child protection unit managers for advice on operational issues. It is available on DHS' website.

Another document used by child protection practitioners is the Best Interests Case Practice Model guide. Released to support the Child FIRST reforms, the document aims to unify social work knowledge and practice about how to make decisions in the best interests of the child. It is intended to be used by workers across the spectrum of early intervention, family and statutory child protection services. The Best Interests Case Practice Model suggests decision making should focus on the safety, stability and development needs of the child in addition to the best interests principles contained in the CYF Act (DHS 2011c).

2. Phase 1: Intake

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

The Inquiry understands that the main 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.

In the course of carrying out the above activities, data and information is collected by DHS that indicates the nature and extent of vulnerability in the community. This indirectly enables forecasting of demand for welfare services and can be used to inform budget and resourcing deliberations.

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. When reports are made to Child FIRST, if the concerns are of a serious nature, they are referred on 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, interstate and overseas statutory child protection authorities. Some classes of people are required by law to report suspected child abuse or neglect and these are discussed in more detail in Chapter 14.

Reports convey a wide range of concerns about a child or young person's wellbeing. Most members of the public would automatically conclude that a report, by and of itself, constitutes a serious indicator of risk that a child may be suffering abuse or neglect. A closer look at the nature and variety of reports, however, reveals a more complicated picture of this community surveillance mechanism.

Two different types 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 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.

The distinction between the types of reports prioritises government intervention, reflecting that statutory investigation and monitoring of children and young people's wellbeing, that disrupts their family should only occur when it is considered necessary to protect the safety of a child.

Making decisions about reports

DHS child protection intake ultimately holds decision making authority over whether a report is characterised as a wellbeing report or a protective intervention report.

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. This work involves assessing and forming professional judgments about what level of risk exists to a child's safety and wellbeing. This may involve consulting with professionals, for example, medical practitioners, nurses or teachers who are aware of the child's situation.

Through this process, child protection intake practitioners are acting as a gateway to statutory services; they are responsible for deciding whether a report is serious enough to trigger the use of statutory powers for government to intervene in the private family setting, to ensure a child's safety. Demand pressures, rather than a focus on a child's needs may also influence intake decision making.

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 support services may be made instead of an investigation. The vulnerable child or their family may be referred to services relevant to their circumstances, for example, they may be referred to a family violence, housing or mental health service provider. The success of any referral depends on the availability of these family and social services. Currently, there are no systematic follow-up mechanisms for child protection statutory services to monitor or determine whether the family concerned successfully takes up the service. On a case by case basis, the community based child protection practitioner may follow-up cases with Child FIRST intake.

Another option for a child protection practitioner is to determine that no further actions should be taken in relation to a report. If this is the case, then the matter will be closed, as it may be at any point in the phases of statutory child protection services.

To assist with the interface between child protection intake and community-based services delivered by CSOs, a DHS child protection intake practitioner is based in each of the 26 Child FIRST alliance locations. Their role includes ensuring that only protective intervention reports are referred to child protection intake. The Child FIRST gateway is intended to receive only the lower risk, wellbeing reports.

Decisions about reports take place in a policy environment where there is an increasing emphasis on the role of family support services to assist vulnerable families to care for and protect their children. Child protection practitioners are balancing the imperative to ensure an individual child or young person's immediate safety, with the policy objective that government's role is to support Victorian families. These competing policy objectives mean that intake services must constantly question whether a given situation is one that requires statutory intervention to meet the needs of a child, that is, whether that child's family has placed the child in a situation of risk that is unacceptable to society and requires a statutory investigation, which must take precedence over the need to support the family.

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. As a result, overlap can exist between the intake reports received by child protection intake, and reports received by Child FIRST and referred to child protection intake.

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, or a physician may report the discovery of cigarette burns on a child's body. These reports provide clear grounds for a thorough investigation and often lead to government intervention.

Other reports are less clear-cut, covering issues such as a child's appearance and behaviour at school, or information about a parent's behaviour, witnessed at what might have been a one-off incident. Reports are also made about unborn children where concerns are held for the child's wellbeing after birth. Other reports might have been made by relatives or neighbours where the concerns for the child may or may not be genuine.

Some reports reflect wider social issues, such as the economic circumstances of the family, or the incidence of mental health problems. If a family is homeless and seeking assistance from housing and other social welfare services, these service providers might each report concerns about that family's child. Although the child may not be at immediate risk of abuse from their caregiver, they are clearly highly vulnerable, if they are without secure and stable housing.

Each individual report about a child therefore reflects a unique combination of situational factors and risks, which are dynamic, and may not directly point to significant abuse or neglect.

The grounds of harm that authorise government intervention are where:

- A child is abandoned by their parents who cannot be found or no other suitable person can be found willing and able to care for the child;
- A child's parents are dead or incapacitated and no other suitable person is willing and able to care for the child;
- A child has (or is likely to) suffer significant harm as a result of the following and their parents have not (or are unlikely to) protect them from that harm:
  - physical injury;
  - sexual abuse; and
  - emotional or psychological harm of such a kind that the child's emotional or intellectual development is, (or is likely to be) significantly damaged.
- A child's physical development or health has (or is likely to) be significantly harmed and the child's parents are not providing or arranging for basic care or effective medical, surgical or other remedial care (s. 162, CYF Act).

In 2005, the notion of cumulative harm to a child was incorporated into the statutory grounds for intervention. Protective intervention now includes when harm is caused by not only single acts, omissions or circumstances causing significant harm but may also be accumulated through a series of acts, omissions or circumstances (s. 162(2), CYF Act). Decision-makers are required to consider the effects of cumulative patterns of harm on a child's safety and development when they are considering the best interest of the child (s. 10(3)(e), CYF Act).

Factors that influence intake decision making

The Practice Manual specifies that child protection intake practitioners must take account of a variety of factors when determining how to action a report. These factors reflect the level of risk found to be present for particular situations: where the child is under two years of age, where the child is Aboriginal or is the subject of a re-report, or where there has been a threat to kill the child.

Under current procedures, a high risk infant manager or specialist practitioner must be involved to assist with intake decisions where the child is under two years of age (DHS 2011k, advice no. 1172). Where the child is Aboriginal, consultation with the Aboriginal Child Specialist Advice and Support Service (ACSASS) should occur to inform the intake decisions.

Decision making requirements are embedded into the child protection client information system (known as CRIS), via workflow, security and access mechanisms. For example, when a child has been reported three times in a 12-month period, the case is flagged, requiring a higher level of authorisation before it may be closed.

3. Phase 2: Investigation

The Inquiry understands that 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 collaborates 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 occurs in a way that is in the best interests of the child (s. 205). Child protection intake report to police all allegations and situations of sexual abuse, physical abuse or serious neglect (DHS 2011k, advice no. 1184; protocol agreement with Victoria Police). Victoria Police may be required to attend a house visit if the circumstances are dangerous to ensure the child protection practitioner is safe or execute a Children's Court warrant for the apprehension of a child or young person.

DHS has determined that where a protective intervention report has been assessed as urgent, the child protection practitioners must visit the child and family within two days of receipt of the report. If the report is not urgent, the visit must occur within 14 days (DHS 2011k, advice no. 246).

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 refuse to participate in an investigation, child protection practitioners must seek court authorisation to require information to be collected. Again, Victoria Police participation may be required to execute a Children's Court warrant to facilitate this.

Investigations primarily focus on investigating the validity and seriousness of reported concerns about a child's safety and the conduct of their parents. The child protection practitioner visiting the home of a child is assessing the risk of harm to the child and in some cases, gathering evidence that could be used as the basis for urgent legal proceedings.

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. Empathy, judgment and excellent communication skills are required to carry out effective interviews with potentially traumatised children and hostile families about allegations and concerns for a child's wellbeing. Ideally, an investigation will result in statutory child protection services working with a family on a voluntary basis and assisting them to care for their child.

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.

When a child protection practitioner finds that a child has suffered significant harm, a protective intervention report is said to be substantiated.

DHS requires child protection practitioners, in consultation with their supervisors, to make substantiation decisions within 28 days of receiving a protective intervention report.

Once substantiation decisions are made, the child protection practitioner then decides the type of further interventions required to ensure the safety, stability and development of the child. These decisions are significant and should be recorded as part of child protection case planning (s. 166, CYF Act).

Child protection case planning

Case planning is central to the manner in which child protection practitioners make decisions about the child. Although a formal case plan is not legally required until a court order has been issued about a child, case planning 'is a significant consideration from the receipt of the report through to the closure of the case' (DHS 2011k, advice no. 1,282, p. 3).

Case planning occurs in a variety of ways across the different phases of statutory child protection services. Up until the point of receiving a court order, the specific case planning activities carried out will depend on the circumstances of the vulnerable child or person concerned. There are more standards and requirements for case planning processes after a court order has been issued.

Case planning activities refer to the way in which child protection practitioners, with families and other professionals, identify issues of concern about the welfare of the child and the changes a family needs to make to improve conditions for their children. It involves setting goals for the future, defining objectives and agreeing on strategies to achieve them. Planning involves looking ahead to identify what can or should be achieved to protect children from harm and promote their stability and healthy development. Planning also sets timelines for action and assigns responsibility for critical tasks. Planning must be documented (DHS 2011k, advice no. 1,282, p. 2).

Outcomes of investigation

The main outcomes of investigations can result in the report being substantiated or not-substantiated. A case might also be closed at this stage. Case closure can occur at any point if no grounds for further statutory intervention are found.

In the event that the report is substantiated, it may proceed to the protective intervention phase, be referred to family support services, or alternatively result in the provision of advice or no further action. The latter may occur in cases where the report is substantiated, but the child is no longer deemed to be at risk of harm.

In the event that the report is not substantiated, it will not proceed to protective intervention, but may result in a referral to family support services, or closure with advice to the family or no further action.

Investigation decision making

As with the intake phase, the Practice Manual provides for internal rules and procedures regarding investigation decision making. There are specific standards that apply to decision making in respect of children under two years of age, Aboriginal children and circumstances where a threat to kill a child has been made.

Phase 3: Protective intervention and assessment

The Inquiry understands 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 collaborates 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; 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 a child's needs and ensure their safety and wellbeing.

In practice, in the previous two phases, child protection practitioners focused primarily on the safety needs of the child by making decisions about whether significant harm or abuse has been suffered and what the level of risk is to a child.

Meeting the safety needs of a child involves a continual reassessment of risk; the paramount concern of statutory child protection services. Family circumstances are dynamic and child protection practitioners are continually revising available information to inform their judgment about the level of risk for a child or young person.

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

There are times when child protection practitioners are unable to work voluntarily with a family and immediate steps are required to secure a child's safety. In these cases, the practitioner will make a protection application to the Children's Court seeking orders so that they can use a number of supervisory powers or make alternative care decisions about where and how a child or young person should be cared for.

Child protection practitioners can work with a family for up to 90 days without a court order. Beyond 90 days, case review is escalated within DHS so that more senior practitioners determine whether court involvement is required or if the case should instead be closed because the family has demonstrated that they are able to care for their child. After 150 days of intervention, the manager of DHS child protection services reviews the case and determines next steps. The time spent by case in this phase is analysed further in Chapter 9 in section 9.3, examining the performance of statutory services.

At the protective intervention and assessment phases, although risks to a child's safety remain the overarching concern, child protection practitioners broaden their assessment and decision making to include other types of needs such as health and developmental needs. The activities involved 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.

As part of information-gathering, family group meetings may be held where the child protection practitioner can discuss issues and next steps with a child's family. Health assessments may be sought from maternal and child health nurses or other health professionals. Parenting assessments may be required from CSOs such as the Queen Elizabeth Centre or the Tweddle Child and Family Health Service. All of this information informs the child protection practitioner's judgment about 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 these assessment activities and written records of planning meetings and decisions should be made by the child protection practitioner (DHS 2011k, advice no. 1,282, p. 5).

Case planning is 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 during the protective intervention phase 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 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.

The decision making required at this phase is a judgment by the child protection practitioner about whether voluntary engagement with the family will be effective or whether mandatory or statutory powers are required. For immediate decision making, child protection practitioners are balancing the potential for further or future harm, against the trauma the child will suffer if separated from their family and primary caregivers.

Quality assessments therefore require child protection practitioners to have sufficient time to carry out a thorough assessment to inform their planning and decision making. Support, supervision, training and ongoing professional development to support this work is critical. Chapter 16 on the workforce discusses the links between capacity and practice.

4. Phase 4: Protection order

If a child protection practitioner has determined 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, that is to:

- Continue 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 collaborates with relevant members of the child and family's network;
- Work effectively with other professionals involved in providing care and services to the child and their family to enable ongoing holistic and accurate assessments of a child's needs; and
- Plan and take actions for reunification of children with their families, where that is in the child's best interests.

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 family's life. The orders procedure adds an additional layer of accountability, as the child protection practitioner will now be responsible to the court in relation to the specific conditions of the order.

The different types of protection orders and associated Children's Court processes are examined in detail with recommendations for simplification proposed in Chapter 15.

Although child protection practitioners may seek orders to remove a child from their home and place them in alternative care, the continuing goal is for a child to remain in the care of their family where it is safe to do so. This is because of the foundational principle that a child's needs are best met in the care of their family. Child protection services aim to empower and support vulnerable families so they can care for their children.

Additional case management activities carried out by child protection practitioners during the protection order phase 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.

As noted above, family circumstances are dynamic and a child protection practitioner must ensure new information, especially new allegations of abuse, are investigated and incorporated into case assessment and planning. Accordingly, variations to court orders may be necessary and these are discussed in Chapter 15.

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). As noted above, 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 notes that the case plans developed at the protection order phase are more detailed than the plans developed in the previous protective intervention phase (DHS 2011k, advice no. 1,282, p. 15). Because of the increased gravity of the accompanying proceedings determining the rights and responsibilities of parents over their children, the CYF Act requires that protection order case plans are provided to the child and their parents within two weeks of being prepared, that is, within eight weeks of an order being made.

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. If a child chooses not to attend (and some children do not want to be involved in these meetings) then practitioners are encouraged to explore more creative ways for the child's voice to be heard for example, through a tape recording, teleconference or a piece of writing that could be read at the meeting (Insert reference to practice standard number).

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 (ss. 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. 1,284 & 1,282);
- Stability plans: prepared for children placed in out-home care (s. 170, CYF Act);
- Education support plans: prepared for children placed in out-of-home care (DHS 2011k, advice no. 1,284); and
- Leaving care plans (DHS 2011k, advice no. 1,418).

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.

DHS stipulates a number of standards and procedures for case plans through the Practice Manual. For example, a plan must be reviewed every six months to assess efficacy of interventions and changes in a child and parent's circumstances.

As with case planning in earlier phases, a high-quality plan should be prepared in a collaborative manner, where all members of the child and family's network have informed planning and decision making. Family group meetings or conferences, where all interested people can be present, are effective mechanisms to achieve these objectives.

Planning meetings are designed to draw on the capacities of the family and the community to generate solutions for addressing a child's needs. Particularly at the protective order phase, there may be significant conflict between the family and child protection practitioners as to the key issues of concern and the most appropriate next steps.

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, 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 ensuring their future safety and wellbeing in that home.

When making reunification decisions, child protection practitioners are balancing the level of risk of harm of the child against the known harm that is caused to a child's development and wellbeing needs when they are removed from their family.

The decision making threshold child protection practitioners must apply is the question of whether a child can be safely returned to their home environment, or whether alternative, long-term or permanent arrangement are instead in the best interests of that child.

In making these decisions, one of the considerations applied by DHS is the need for a child to be placed in a stable, caring environment, as multiple placements over time have a severely detrimental impact on a child's health needs and particularly on their mental health.

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

Permanency planning

Permanency planning is a relatively recent area of policy development in Australian child protection. Permanency planning refers to activities undertaken to plan and prepare for a child to be placed in a long-term care arrangement where circumstances are such that the child cannot continue to be cared for by his or her natural parents (Bromfield & Holzer 2008, p. 23).

It is desirable that if a child requires permanent alternative care to their birth family, that this decision be made when they are as young as possible so that they can bond with the new family as early as possible in their life. Such decisions reduce the likelihood of multiple placements.

6. 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.

For particular types of cases, such as high-risk infants, high-risk adolescents and Aboriginal children, additional processes are specified in the Practice Manual.

Appendix 10: Summary of Aboriginal specific services

10.1 Early childhood

10.1.1 State programs

In Victoria there is a range of early childhood services and additional targeted services provided by the state government for Aboriginal children and their families. The early childhood services are summarised below.

Early childhood programs/services	Additional programs/services for Aboriginal children and families
Best Start	Aboriginal Best Start
Maternity Services	Koori Maternity Service
Maternal and Child Health Service	Indigenous kindergarten program
Maternal and Child Health Line	Koori Engagement Support Officers
Child care	Koori preschool assistants
Four year old kindergarten (including fee subsidy for eligible children)	Free kindergarten (for up to 10 hours) for 3 and 4 year old Aboriginal children
Parentline	In Home Support
Supported playgroups and parent groups (SPPI)	Home Based Learning
Early Childhood Intervention Services	Aboriginal supported playgroups
School	

Aboriginal Best Start

Best Start is an early intervention and prevention program aiming to improve health, development, learning and well- being of Victorian children from conception to eight years of age (school transition). The program aims to achieve this by bringing together parents, health, education, community services and government at the local level in partnerships concentrating on needs of young children.

There are 30 Best Start project sites across the state. Six of these sites focus specifically on working with Aboriginal communities. Local partnerships are the cornerstone of each project site. Two enhanced Best Start projects (in Mildura and Shepparton) have been allocated additional funding to trial some initiatives to improve outcomes for more vulnerable children, including those known to statutory child protection services.

Koorie Maternity Service

Culturally appropriate maternity care is provided to Aboriginal and Torres Strait Islander women throughout pregnancy, working with hospitals for birth and during the postnatal period through Victorian Aboriginal Community Controlled Health Organisations (VACCHOs) in 10 sites throughout Victoria.

There are two key ways in which care is provided. The first involves an Aboriginal maternity health worker and a midwife, who are both employed by the Aboriginal health service. They combine their skills to offer a comprehensive service to women in the local community, including a clinical component.

The second employs an Aboriginal health worker who supports women during pregnancy and after birth and is responsible for linking Aboriginal women with appropriate clinical service providers.

Indigenous kindergarten program

This initiative provides assistance to Aboriginal children to participate in three- and four year old kindergarten. Free kindergarten of up to 10.75 hours per week for these children is available.

Koori Engagement Support Officers

Koori Engagement Support Officer is a new professional role that is responsible for delivering support and services to Koori children and their families through their regions and replaces the past Koori educators, Koori education development officers, Koori early childhood field officers, and home school liaison officer positions.

Koori preschool assistants

The Koori pre-school assistants (KPSA) program is auspiced by community-based organisations. KPSAs work within kindergarten programs and Koori communities to:

- Enhance the access and participation of Koori children in kindergarten programs;
- Promote and assist in the delivery of Koori inclusive programs;
- Provide information and support to Koori families and communities;
- Support the attendance of Koori children in kindergarten programs;
- Encourage the involvement and participation of Koori parent/families/carers in the development of kindergarten programs; and
- Assist in the development of kindergarten programs that embrace Koori culture.

In-Home Support Program / Home Based Learning

In-Home Support is a program for parents with children aged from 0 to three years. The program involves workers modelling skills to parents in their homes, and through playgroups and group activities. Home Based Learning is for families with children aged three to five years and it focuses on school readiness and empowering Aboriginal parents as the first educators of their children. In-Home Support is now operating in six sites with a standardised curriculum and a program of professional development. Three of these sites are also funded for the Home Based Learning program.

Aboriginal supported playgroups and parent groups

Aboriginal supported playgroups and parent groups provide regular high-quality play opportunities at a critical time in a child's development. These opportunities foster language and motor skill development, expose children to sensory experiences and enhance social skills.

10.1.2 Commonwealth programs

The Commonwealth funds a number children's services in Victoria for Aboriginal communities including the following:

Multi-functional Aboriginal Children Services (MACS)

MACS are a Commonwealth funded program that was established in 1980 as Aboriginal community controlled and multi-faceted child care services funded to meet the educational, social and developmental needs of Aboriginal children, MACS predominantly provide long day care services and at least one other form of child care or activity – such as outside school hours care, play groups, nutrition programs and/or parenting programs – to the community based on local needs. Six MACS operate in Victoria:

- Berrimba Child Care Centre, Echuca;
- Bung Yarnda MACS, Lake Tyers;
- Gunai Lidj MACS, Morwell;
- Lulla's Children and Family Centre, Shepparton;
- Robinvale MACS, Robinvale; and
- Yappera MACS, Thornbury.

Under the National Partnership Agreement for Indigenous Early Childhood Development, work is proceeding to maximise integration of a range of maternal and child health, kindergarten and other family and community services through MACS.

Aboriginal Children and Family Centres

The Council of Australian Governments (COAG) National Partnership for Indigenous Early Childhood Development provides increased access to child and maternal health services and better integration of child and family services to improve Indigenous child mortality. This includes the establishment of two Aboriginal Children and Family Centres, one in Whittlesea and one in Bairnsdale.

The centres will provide a mix of early childhood and family support services, including long day care, kindergarten for three and four year-old Aboriginal children, visiting professionals such as maternal and child health nurses, counsellors, midwives, Koori early childhood field officers and other programs including In-Home Support and Early Childhood Intervention Services. Plans are in place to also deliver increased access to antenatal care, pre-pregnancy and teenage sexual and reproductive health in the two new centres.

10.2 Education

There is a range of Aboriginal specific services and processes in DEECD under the The Wannik strategy. Each region has a regional Koori education coordinator and Koori engagement support officers. The Koori engagement support officers work across families and schools to improve participation and educational outcomes.

Koori Education Coordinators

Nine Koori Education Co-ordinator (KEC) positions have been created (one per region) to support the provision of greater management responsibility by regions to ensure that the support services are directed to the areas of greatest need in respect to Koori education. The KEC role focuses on coordinating a collaborative and consistent strategy for Koori education across the region, provides a strategic link between relevant DEECD employees and external agencies, and develops and coordinates the delivery of relevant training and professional development for the Koori education workforce.

Koori Engagement Support Officer

Koori Engagement Support Officer is a new professional role that is responsible for delivering support and services to Koori children and their families through their regions and replaces the past Koori educators, Koori education development officers, Koori early childhood field officers, and home school liaison officer positions.

10.3 Family services

As outlined in Chapter 8 on early intervention, in Victoria there is a range of family service programs that can be accessed through Child FIRST. Family services have a critical role in promoting outcomes for vulnerable children and families.

There are a number of specific programs for Aboriginal families funded by the DHS and provided by ACCO's as listed below.

Aboriginal integrated family services

Each of the 24 Child FIRST catchments have a local alliance consisting of the local family service providers and child protection services. As part of the local Alliance ACCO's operate Aboriginal family services in 18 of the 24 catchments.

Aboriginal Family Preservation

Aboriginal Family Preservation programs were first established in five Victorian communities between 1998 and 2000. One new program was established in 2007. The program gives intensive support over a short period of time to either prevent the need for children to be placed away from home or enable children to return home.

Aboriginal Family Restoration

Aboriginal Family Restoration programs provide intensive support while offering the additional benefits of a residential based program for the whole family. Commencing in 2006-07 there are three Aboriginal Family Restoration programs in Victoria. One of these is an integrated family preservation and restoration model.

Cultural competence of mainstream agencies

The registration process for community service organisations (CSOs) (refer to Chapter 21) has a standard related to cultural competence in the provision of services for Aboriginal children, young people and families. The performance of CSO's 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 (2007-2010) records the results from this review process.

10.4 Child protection

Chapter 9 describes the statutory child protection statutory service system. In addition there is a range of Aboriginal specific services that statutory child protection services use. These services include:

- State-wide Aboriginal Child Specialist Advice and Support Service (ACSASS); and
- Aboriginal Family Decision Making (AFDM);

There are also a range of Aboriginal specific processes that statutory child protection services use. These include:

- Cultural Support Plan (CSP);
- The Aboriginal Child Placement Principle; and
- Section 18 of the CYF Act 2005.

Where Aboriginal children must be placed away from home, it is critical that their links with family and community are preserved and strengthened. Legislation requires that all Aboriginal children and young people who are in an out-of-home care placement and are subject to a Guardianship to Secretary Order or Long Term Guardianship to Secretary Order have a CSP.

This legislative requirement is a response to research findings that for many Aboriginal young people, positive self-esteem is closely linked to meaningful participation in community and connection with a larger sense of their personal and cultural identity. The CSP is used as a tool to ensure Aboriginal children who are placed in out-of-home care remain connected to their families, communities and culture. Child protection workers are responsible for ensuring that CSPs are implemented, reviewed and monitored. Aboriginal Family Decision Making community conveners develop the CSP in consultation with relevant professionals, family and extended family members, respected Elders and community, both locally and, as is often needed, more broadly.

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;
- Placement within the child's Aboriginal community; and
- Placement with other Aboriginal people.

Section 18 of the CYF Act 2005 allows the Secretary of DHS to authorise the principal officer of an Aboriginal Agency to exercise specified powers in relation to a protection order for a child. Since August 2007, the Child Protection, Placement and Family Services Branch has been working with stakeholders, including ACCOs, to guide the considerable policy development and capacity building work that is required to implement section 18. This section of the CYF Act has not yet been utilised.

State-wide Aboriginal Child Specialist Advice and Support Service (ACSASS)

ACSASS is funded by DHS to provide cultural advice to statutory child protection services regarding Aboriginal children and young people reported to statutory child protection services. Advice is provided on all significant decisions and actions concerning Aboriginal children and young people, through all stages of intervention, to ensure a culturally appropriate and effective service response to Aboriginal children at risk of harm. These arrangements are outlined in the 2002 DHS Protocol between the Department of Human Services Child Protection Service and the Victorian Aboriginal Child Care Agency.

Aboriginal Family Decision Making (AFDM) program

AFDM is a state-wide program that aims to enhance the quality and sustainability of case decisions for Aboriginal children who are subject to child protection intervention following the substantiation of a report to statutory child protection services, by directly involving extended family and community members in planning for the child. The family are assisted in this by co-conveners, one from the DHS and one an Aboriginal convener working from an ACCO. The involvement of respected Aboriginal Elders gives authority to the process and assists the family in planning for their children in a culturally appropriate way to meet their safety and development needs.

An AFDM meeting can be used for Aboriginal children and young people instead of the planning meeting that must be held within six weeks of a child protection order being made.

Out-of-home care

There are a number of Aboriginal specific processes and programs in relation to out-of-home care. These include:

- Two Aboriginal specific therapeutic residential care pilots;
- Culturally competent foster care model;
- Aboriginal kinship care program; and
- Family Coaching Pilots.

Aboriginal kinship care

Recognising that Aboriginal children have unique cultural needs and complex circumstances, services, which include access to support groups, information and training, will equip carers to provide the support needed to ensure that Aboriginal children can stay with their families in a safe and culturally appropriate environment

Family coaching pilots

New family-based interventions that aim to prevent at-risk children and young people being removed from home, are being piloted in four Child FIRST sites between 2010 and 2013. This new service (known as 'Family Coaching Victoria') provides integrated and coordinated placement prevention and reunification service response to vulnerable children and their families with substantiated child protection concerns. Children and their families receive therapeutic child and family assessment and support for up to 12 months, with support individually tailored to their needs from a range of services which include intensive services, therapeutic treatment and support, residential and in-home parenting support, practical support, respite and child care.

Appendix 11: Convictions and sentencing for specific sexual offences against children

Sentencing and sexual offences against children	03/04	04/05	05/06	06/07	07/08	08/09	09/10
Indecent act with a child (aged under 16)							
Persons sentenced (number 'n')	25	26	23	31	35	39	29
Immediate custodial sentence (n)	13	8	13	17	26	22	24
Average principal sentence (year/month)	1/6	1/11	1/9	1/11	1/6	2/6	2/0
Incest							
Persons sentenced (n)	25	32	21	33	48	33	n/d
Immediate custodial sentence (n)	24	30	21	31	45	31	n/d
Average principal sentence (year/month)	3/11	3/6	3/11	4/2	4/1	4/3	n/d
Sexual penetration of a child (aged 10 to 16) under care, supervision or authority							
Persons sentenced (n)	5	9	7	6	9	9	7
Immediate custodial sentence (n)	3	8	7	5	7	8	6
Average principal sentence (year/month)	3/2	3/2	2/8	8/0	3/11	2/9	3/5
Sexual penetration of a child (aged under 10)							
Persons sentenced (n)	16	26	16	17	17	20	8
Immediate custodial sentence (n)	13	14	11	16	14	14	6
Average principal sentence (year/month)	4/1	3/2	3/8	3/2	3/4	4/1	3/9
Sexual penetration of a child (aged 10 to 16)							
Persons sentenced (n)	29	45	45	57	92	79	56
Immediate custodial sentence (n)	9	20	28	24	44	36	31
Average principal sentence (year/month)	1/11	2/7	2/0	2/8	2/1	2/5	3/0
Maintaining a sexual relationship with a child under 16							
Persons sentenced (n)	5	12	3	10	11	9	13
Immediate custodial sentence (n)	4	11	3	10	9	9	13
Average principal sentence (year/month)	4/1	5/6	5/8	6/0	5/4	6/9	5/6

N/d = no data available

Appendix 12: Mandatory reporting requirements across Australia

	Who is mandated to notify?	What is to be notified?	Maltreatment types for which it is mandatory to report	Relevant sections of the Act/Regulations
ACT	A person who is: a doctor; a dentist; a nurse; an enrolled nurse; a midwife; a teacher at a school; a person providing education to a child or young person who is registered, or provisionally registered, for home education under the Education Act 2004; a police officer; a person employed to counsel children or young people at a school; a person caring for a child at a child care centre; a person coordinating or monitoring home-based care for a family day care scheme proprietor; a public servant who, in the course of employment as a public servant, works with, or provides services personally to, children and young people or families; the public advocate; an official visitor; a person who, in the course of the person's employment, has contact with or provides services to children, young people and their families and is prescribed by regulation	A belief, on reasonable grounds, that a child or young person has experienced or is experiencing sexual abuse or non-accidental physical injury; and The belief arises from information obtained by the person during the course of, or because of, the person's work (whether paid or unpaid)	Physical abuse Sexual abuse	Section 356 of the *Children and Young People Act 2008* (ACT)
NSW	A person who, in the course of his or her professional work or other paid employment delivers health care, welfare, education, children's services, residential services or law enforcement, wholly or partly, to children; and A person who holds a management position in an organisation, the duties of which include direct responsibility for, or direct supervision of, the provision of health care, welfare, education, children's services, residential services or law enforcement, wholly or partly, to children	Reasonable grounds to suspect that a child is at risk of significant harm; and Those grounds arise during the course of or from the person's work	Physical abuse Sexual abuse Emotional/psychological abuse Neglect Exposure to family violence	Sections 23 and 27 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW)
NT	Any person with reasonable grounds	A belief on reasonable grounds that a child has been or is likely to be a victim of a sexual offence; or otherwise has suffered or is likely to suffer harm or exploitation	Physical abuse Sexual abuse Emotional/psychological abuse Neglect Exposure to physical violence (e.g., a child witnessing violence between parents at home)	Sections 15 and 26 of the *Care and Protection of Children Act 2007* (NT)

	Who is mandated to notify?	What is to be notified?	Maltreatment types for which it is mandatory to report	Relevant sections of the Act/Regulations
	Registered health professionals	Reasonable grounds to believe a child aged 14 or 15 years has been or is likely to be a victim of a sexual offence and the age difference between the child and offender is greater than 2 years	Sexual abuse	Section 26 of the *Care and Protection of Children Act 2007* (NT)
Qld	An authorised officer, employee of the Department of Communities (Child Safety Services), a person employed in a departmental care service or licensed care service	Awareness or reasonable suspicion of harm caused to a child placed in the care of an entity conducting a departmental care service or a licensee	Physical abuse Sexual abuse or exploitation Emotional/psychological abuse Neglect	Section 148 of the *Child Protection Act 1999* (Qld)
	A doctor or registered nurse (*Public Health Act 2005*, s158)	Awareness or reasonable suspicion during the practice of his or her profession of harm or risk of harm		Sections 191-192 and 158 of the *Public Health Act 2005* (Qld)
	The Commissioner for Children and Young People	A child who is in need of protection under s10 of the Child Protection Act (i.e. has suffered or is at unacceptable risk of suffering harm and does not have a parent able and willing to protect them)		Section 20 of the Commission for *Children, Young People and Child Guardian Act 2000* (Qld)
SA	Doctors; pharmacists; registered or enrolled nurses; dentists; psychologists; police officers; community corrections officers; social workers; teachers; family day care providers; employees/ volunteers in a government department, agency or instrumentality, or a local government or non-government agency that provides health, welfare, education, sporting or recreational, child care or residential services wholly or partly for children; ministers of religion (with the exception of disclosures made in the confessional); employees or volunteers in a religious or spiritual organisations	Reasonable grounds that a child has been or is being abused or neglected; and The suspicion is formed in the course of the person's work (whether paid or voluntary) or carrying out official duties	Physical abuse Sexual abuse Emotional/psychological abuse Neglect	Section 11 of the *Children's Protection Act 1993* (SA)

Appendix 12: Mandatory reporting requirements across Australia (continued)

	Who is mandated to notify?	What is to be notified?	Maltreatment types for which it is mandatory to report	Relevant sections of the Act/Regulations
Tas	Registered medical practitioners; nurses; dentists, dental therapists or dental hygienists; registered psychologists; police officers; probation officers; principals and teachers in any educational institution; persons who provide child care or a child care service for fee or reward; persons concerned in the management of a child care service licensed under the Child Care Act 2001; any other person who is employed or engaged as an employee for, of, or in, or who is a volunteer in, a government agency that provides health, welfare, education, child care or residential services wholly or partly for children, and an organisation that receives any funding from the Crown for the provision of such services; and any other person of a class determined by the Minister by notice in the Gazette to be prescribed persons	A belief, suspicion, reasonable grounds or knowledge that: A child has been or is being abused or neglected or is an affected child within the meaning of the Family Violence Act 2004; or There is a reasonable likelihood of a child being killed or abused or neglected by a person with whom the child resides	Physical abuse Sexual abuse Emotional/psychological abuse Neglect Exposure to family violence	Sections 13 and 14 of the Children, Young Persons and Their Families Act 1997 (Tas)
Vic	Registered medical practitioners, registered nurses, a person registered as a teacher under the Education, Training and Reform Act 2006 or teachers granted permission to teach under that Act, principals of government or non-government schools, and members of the police force	Belief on reasonable grounds that a child is in need of protection on a ground referred to in Section 162(c) or 162(d), formed in the course of practising his or her office, position or employment	Physical abuse Sexual abuse	Sections 182(1) a-e, 184 and 162 c-d of the *Children, Youth and Families Act 2005* (Vic.)

	Who is mandated to notify?	What is to be notified?	Maltreatment types for which it is mandatory to report	Relevant sections of the Act/Regulations
WA	Court personnel; family counsellors; family dispute resolution practitioners, arbitrators or legal practitioners representing the child's interests	Reasonable grounds for suspecting that a child has been: abused, or is at risk of being abused; ill treated, or is at risk of being ill treated; or exposed or subjected to behaviour that psychologically harms the child	Physical abuse Sexual abuse Emotional/psychological abuse Neglect	Section 160 of the *Western Australia Family Court Act 1997* (WA)
	Licensed providers of child care or outside-school-hours care services	Allegations of abuse, neglect or assault, including sexual assault, of an enrolled child during a care session	Physical abuse Sexual abuse Neglect	Regulation 20 of the Child Care Services Regulations 2006; Regulation 19 of the Child Care Services (Family Day Care) Regulations 2006; Regulation 20 of the Child Care Services (Outside School Hours Family Day Care) Regulations 2006; Regulation 21 of the Child Care Services (Outside School Hours Care) Regulations 2006
	Doctors; nurses and midwives; teachers; and police officers	Belief on reasonable grounds that child sexual abuse has occurred or is occurring	Sexual abuse	Section 124B of the *Children and Community Services Act 2004* (WA)

Appendix 13: Failure to protect laws in the United Kingdom, South Australia and New Zealand

	United Kingdom	South Australia	New Zealand
Act	*Domestic Violence, Crime and Victims Act 2004*	*Criminal Law Consolidation Act 1935*	*Crimes Amendment Act (No.3) 2011* (yet to commence)
Victim	Child (under 16 years) or vulnerable adult (defined as a person aged 16 or over whose ability to protect her/himself from violence, abuse or neglect is significantly impaired through physical or mental disability or illness, through old age or otherwise)	Child (under 16 years) or vulnerable adult (defined as aged 16 years or over whose ability to protect her/himself from an unlawful act is significantly impaired through physical or mental disability, illness or infirmity)	Child (under 18 years) or vulnerable adult (defined as a person unable by reason of detention, age, sickness or mental impairment or any other cause to withdraw her/himself from the care or charge of another person).
Liable persons	Applies to member of household which includes a person even if s/he does not live in that household, if s/he visits it so often and for such periods of time that it is reasonable to regard him or her as a member of it	Applies to a person who has a duty of care to the victim which in the Act is if that person is a parent or guardian or has assumed responsibility for the victim's care	Applies to member of same household or a staff member of any hospital, institution or residence where victim resides Member of same household may include a person not living in the household but is so closely connected to the household having regard to the frequency and duration of visits to the household, whether the person has a familial relationship with the victim and any other relevant matters in the circumstances
Persons who cannot be charged	A person who is under the age of 16 years at time of the act causing victim's death and was not the mother or father of the victim	None expressed	Person under 18 years of age at time of act or omission constituting offence
Scope of offence	At time of death, the person was member of same household as victim; had frequent contact with victim; there was a significant risk of serious physical harm being caused to victim; the person's act either caused the death; or the person ought to have been aware of the significant risk; and failed to take steps that could reasonably be expected to the person to take to protect the victim; and the act occurred in circumstances the person foresaw or ought to have foreseen	Was, or ought to have been aware there was an appreciable risk of serious harm to the victim as a result of the unlawful act; and failed to take steps that s/he could reasonably have taken in the circumstances to protect the victim from harm; and the failure was so serious that a criminal penalty is warranted	Knows a victim is at risk of death, grievous bodily harm, or sexual assault as a result of an unlawful act or omission by another person and fails to take reasonable steps to protect victim from the risk

	United Kingdom	South Australia	New Zealand
Penalty	14 years maximum imprisonment and/or a fine where a child dies	14 years maximum imprisonment where a child dies 5 years maximum imprisonment where child suffers harm	10 years maximum imprisonment (no distinction in penalty depending on severity of outcome – i.e. death or harm)
Defences	None expressly provided	None expressly provided	None expressly provided

Appendix 14: Regulation and oversight supporting information

Table 1 Approaches to regulating providers of services to vulnerable clients

	Out-of-home care and family services	Residential aged care	Home and community care	Disability services	Early childhood education and care
Approval of service providers	All providers must be registered	Providers must be both approved and accredited to receive Commonwealth funding	Providers must be approved to receive Commonwealth funding	All providers must be registered	All providers must be approved
Performance standards	DHS Standards will apply from July 2012	Standards set out in the Quality of Care Principles 1997. Providers' broader responsibilities set out in the *Aged Care Act 1997*	Community Common Care Standards	DHS Standards will apply from July 2012	National Quality Standard for Early Childhood Education and Care
Monitoring and review	Providers to be reviewed against DHS standards once every three years	Providers reviewed against standards in announced or unannounced audits Authorised officers can also conduct inspections to monitor whether providers are meeting broader responsibilities	Providers reviewed against standards once every three years	Providers to be reviewed against DHS standards once every three years Community visitors also inspect residential premises at least once per month, with or without notice	Providers are assessed against standards; frequency of assessments depends on the provider's record Unannounced inspections can also be performed
Sanctions for failing to meet standards	Potential sanctions include renegotiating funding, placing conditions on registration, appointing an administrator, or revoking registration	Potential sanctions include restricting, suspending or revoking approval, or prohibiting the granting of extra services	No direct sanctions for failing to meet standards Review outcomes could inform the Department's funding decisions	Potential sanctions include stopping payments, terminating the contract, removing the Committee of Management, appointing an administrator, or revoking registration	Potential sanctions include suspending or cancelling a provider's approval to operate A range of financial penalties apply for failing to meet certain requirements under the Act

	Out-of-home care and family services	Residential aged care	Home and community care	Disability services	Early childhood education and care
Regulator	DHS (Victoria) Review of standards contracted out to independent organisations	Department of Health and Ageing (Commonwealth) Accreditation and auditing delegated to Aged Care Standards and Accreditation Agency	Department of Health (Victoria) Review of standards contracted out to independent organisations	Department of Human Services (Victoria) Review of standards contracted out to independent organisations	Department of Education and Early Childhood Development (Victoria)
Primary legislation	*Children, Youth and Families Act 2005* (Victoria)	*Aged Care Act 1997* (Commonwealth)	*Aged Care Act 1997* (Commonwealth)	*Disability Act 2006* (Victoria)	*Education and Care Services National Law 2010* (Victoria)

Source: Research conducted for the Inquiry by the State Services Authority

Table 2 Standards for community service organisations and performance criteria

Standard 1 **The CSO has the leadership and management capacity to provide clarity of direction, ensure accountability and support quality and responsive services for children, youth and their families.**	
1.1 Governance	a. The CSO has a Board comprising members with appropriate skills and knowledge. b. The CSO maintains effective governance policies that clearly document roles and responsibilities and delegations of authority for the Governing Body, management, staff and carers and defines acceptable behaviours and practices.
1.2 Strategy & planning	a. The CSO's Board works in partnership with staff, carers, children, youth, families, other services and communities to set strategic directions for the CSO. b. The CSO has business planning processes that are aligned with strategic directions and monitor organisational performance. c. The CSO utilises a risk management process to identify, mitigate and manage risks.
1.3 Financial viability	a. The CSO manages financial resources in a responsible, accountable and prudent manner, which: • maintains financial and organisational viability; • meets financial accountability and reporting requirements; and • promotes quality services, for children, youth and families.
1.4 Information systems	a. The CSO effectively manages information and has information technology systems in place to enable secure data use and storage and to support the CSO's decision-making, service monitoring and accountability requirements.
1.5 Contract management	a. The CSO negotiates contracts in a responsible, accountable and prudent manner and meets contractual requirements.
Standard 2 **The CSO promotes a culture which values and respects children, youth and their families, carers, staff and volunteers.**	
2.1 Culturally competent and inclusive services	a. The CSO provides culturally competent services, which respect the cultural identity of children, youth and families. b. The CSO maintains appropriate community linkages and works in partnership with a range of services, which are relevant to meeting the cultural needs of children, youth and their families.
2.2 Service responsiveness	a. The CSO demonstrates a commitment to improving care and service delivery, through responding to staff, carer, child, youth and family feedback.
2.3 Complaints and allegations management	a. The CSO demonstrates the use of a complaints management system that meets the needs, expectations and rights of complainants and informs policy and practice. b. The CSO ensures that allegations of misconduct and abuse are reported, investigated and the outcomes of any investigation are actioned.
2.4 Information sharing	a. The CSO shares and manages information sensitively to support children and youth's best interests, whilst protecting the right of children, youth and families to privacy and confidentiality.
2.5 Information accessibility	a. The CSO has policies and systems in place to allow children, youth and their family, including former clients, to appropriately access records regarding services provided to them.
2.6 Private space	a. The CSO ensures that the living environment supports the privacy and confidentiality of children and youth in culturally, gender and age and stage appropriate ways (specific to Out of Home Care).

Standard 3 **Staff, carers and volunteers support positive outcomes for children, youth and their families.**	
3.1 Staff/ carer/ volunteer competency	a. The CSO ensures services are delivered by staff, carers and volunteers who have the qualifications, knowledge, values and personal skills, attributes and cultural competence to meet the needs of children, youth and families.
3.2 Staffing and recruitment	a. The CSO ensures that staffing/carer support levels are appropriate to meet the individual needs of children, youth and families.
3.3 Pre-employment and pre-placement checks	a. The CSO applies effective pre-employment checks. b. The CSO has pre-placement assessment and approval processes in place to ensure carers have appropriate skills to meet the needs of children, youth and families (specific to Out of Home Care).
3.4 Training and development	a. The CSO has pre-service training/induction and ongoing development programs for staff, volunteers, carers and other members of the carer's household (as required) which cover: • the CSO's mission, vision and values and supports understanding of how these can be put into practice; • strategies to support capacity building and greater responsiveness to client needs; and • cultural competency practice and related training to support the needs of Aboriginal and culturally and linguistically diverse children, youth and families.
3.5 Supervision, performance monitoring and review	a. The CSO ensures staff, carers and volunteers are supervised and that issues identified via supervision are acted on to meet the ongoing safety and development needs of children and youth. b. The CSO has formal performance reviews and ongoing monitoring practices which confirm the appropriateness of staff and carers and identify the skill development that will contribute to the quality of services being provided.
3.6 Occupational Health and Safety	a. The CSO provides a safe working environment for staff, carers and volunteers.
Standard 4 **The CSO creates a welcoming, safe and accessible environment, which promotes the inclusion of children, youth and families.**	
4.1 Service environment	a. The CSO provides for: • a service environment which is safe and encourages children, youth, families and carers to make initial contact with the service and if required, participate in the longer term; and • services to be accessible for children, youth, families and carers, including those with a disability. b. The CSO provides an environment that is responsive to children and youth's cultural or Aboriginal background, age and developmental stage.
Standard 5 **The CSO promotes the safety, stability and development of children and youth.**	
5.1 Safe and nurturing environment	a. The CSO supports parents and families to create and sustain a safe and nurturing home environment, which supports development and stability of children and youth. b. The CSO ensures children and youth in out of home care live in a safe, culturally appropriate and nurturing environment, free from physical, sexual and emotional abuse and neglect, which supports development and stability (specific to Out of Home Care). c. The CSO ensures that children and youth receive personal items, household provisions and community resources that meet their needs (specific to Out of Home Care).

Table 2 Standards for community service organisations and performance criteria (continued)

5.2 Promoting development	a. The CSO promotes a child or youth's health (including medical, dental and mental health) needs being met. b. The CSO assists in a child or youth's emotional and behavioural development. c. The CSO promotes education and supports children and youth to achieve their educational potential and gain maximum life opportunities through active involvement with appropriate educational and/or training services. d. The CSO assists children and youth to develop, maintain and strengthen their family and social relationships. e. The CSO assists children and youth to develop and maintain their personal, gender, cultural and religious identity and sexual orientation. f. The CSO assists Aboriginal children and youth in their cultural development and maintains their connection to their Aboriginal culture and community. g. The CSO assists children and youth with cultural and linguistically diverse backgrounds to develop and maintain their cultural identity and connection to community. h. The CSO assists children and youth to present well in accordance with their age, gender, developmental stage and culture. i. The CSO assists children and youth to develop independence, problem solving skills and self-care skills appropriate to their age, developmental stage and cultural circumstances.
5.3 Inclusive practice in the best interests of the child and youth	a. The CSO adopts a partnership approach when working with children, youth and their families which is responsive to children's age; gender, culture, communication needs and developmental stage and works to understand their needs and views in the context of the family, community and culture.
Standard 6 **The CSO strengthens the capability of parents, families and carers to provide effective care.**	
6.1 Building capacity	a. The CSO assists parents, families and carers to engage in continuous development of their understanding of normal child development and parenting/caring skills to increase their confidence and capability to meet the safety, stability and development needs of their child or youth. b. The CSO assists parents, families and carers to effectively manage transition of children and youth between service providers and sectors and from out of home care to the family home or independent living. c. The CSO establishes and leads a care team which is responsible for the planning and provision of care for each child and youth in a way that any good parent would naturally consider when caring for their own children (specific to Out of Home Care).
6.2 Family connectedness	a. The CSO assists parents, families and carers to engage with universal services and other secondary and specialist services to promote access to the full range of community supports required to enhance the safety, stability and development of their child or youth. b. The CSO provides parents and families with opportunities to have contact with their child or youth in a flexible manner, in the best interests of the child and youth.
Standard 7 **The CSO provides responsive services to support the best interests of children and youth**	
7.1 Children, youth and family involvement	a. The CSO ensures that children, youth and families are involved in assessment, planning, decision making processes and the actioning of plans in age appropriate, gender sensitive, developmentally and culturally appropriate ways.

7.2 Assessment	a. The CSO ensures that assessment occurs on an ongoing basis to identify the risks and changing needs of the child, youth and their family.
7.3 Planning	a. The CSO ensures that each child, youth and family has a child and family action plan which is reviewed on an ongoing basis to respond to the changing needs of the child, youth and family and includes strategies to: • address issues identified in assessment to support children and youth's safety, stability and development needs in the context of their family, culture and community; • assist parents, carers and families to continuously improve their parenting/caring capability and more effectively meet children and youth's needs; and • assess that service outcomes are achieved (specific to Family Services). b. The CSO ensures that each child and youth has an up to date care and placement plan which is reviewed on an ongoing basis to respond to the changing needs of children, youth and families (specific to Out of Home Care). c. The CSO contributes to the development of statutory case planning directions contained within the overall best interests plan for children or youth placed with their CSO (specific to Out of Home Care).
7.4 Action	a. The CSO ensures that relevant child/youth and family plans are implemented.
7.5 Responding to cultural diversity	a. The CSO in its assessment, planning and actions ensures cultural safety and is respectful to the linguistic, cultural and religious diversity of children, youth and families and uses interpreters where necessary in communication with the child, youth and their family.
7.6 Respecting Aboriginal children and youth's cultural identity	a. The CSO in its assessment, planning and actions promotes cultural safety and respects the cultural and spiritual identity of Aboriginal children and youth in line with their cultural support plan.
7.7 Care and placement management	a. The CSO ensures that children and youth are placed with carers who are best able to meet the child or youth's individual needs (specific to Out of Home Care). b. The CSO ensures placements are provided to ensure stability of care and that where a placement change is required it is planned to support a smooth transition for the child or youth (specific to Out of Home Care). c. For all children and youth whose custody and guardianship remains with their parents, the CSO ensures that child care agreements are negotiated in accordance with Children, Youth and Families Act 2005 (specific to Out of Home Care).
7.8 Preparation for returning to home	a. The CSO works with children and youth to assist and prepare them for returning home (specific to out of home care).
7.9 Preparation for leaving care	a. The CSO works with youth to assist and prepare them for leaving care (specific to out of home care).
Standard 8 **The CSO creates an integrated service response, which supports the safety, stability and development of children and youth.**	
8.1 Collaboration	a. The CSO collaborates in relevant service networks to support better service integration, coordination and earlier intervention and prevention.
8.2 Timely support	a. The CSO demonstrates responsiveness to referrals and requests for services.

Table 2 Standards for community service organisations and performance criteria (continued)

8.3 Access	a. The CSO uses active engagement strategies to establish contact with resistant and hard to engage children, youth and families and encourages the use of services before a crisis arises. b. The CSO provides a visible and accessible point of contact, referral and services for children, youth, families, communities, universal and other secondary/specialist services (specific to Family Services).
8.4 Prioritisation and demand management	a. The CSO works collaboratively with Child FIRST, other family services and in association with Child Protection to apply agreed arrangements to effectively manage demand (specific to Family Services). b. The CSO works collaboratively with placement and support services and Child Protection to apply agreed arrangements to manage demand for out of home care placements (specific to Out of Home Care).

Source: Victorian Government Gazette 2007

Table 3 One DHS Standards and criteria

Standard	Criteria
1. Empowerment People's rights are promoted and upheld.	1.1 People understand their rights and responsibilities.
	1.2 People exercise their rights and responsibilities.
2. Access and Engagement People's right to access transparent, equitable and integrated services is promoted and upheld.	2.1 Services have a clear and accessible point of contact.
	2.2 Services are delivered in a fair, equitable and transparent manner.
	2.3 People access services most appropriate to their needs through timely, responsive, service integration and referral.
3. Wellbeing People's right to wellbeing and safety is promoted and upheld.	3.1 Services adopt a strengths based and early intervention approach to service delivery that enhances people's wellbeing.
	3.2 People actively participate in an assessment of their strengths, risks, wants and needs.
	3.3 All people have a goal oriented plan documented and implemented. This plan includes strategies to achieve stated goals.
	3.4 Each person's assessments and plans are regularly reviewed, evaluated and updated. Exit/transition planning occurs as appropriate.
	3.5 Services are provided in a safe environment for all people, free from abuse, neglect, violence and/or preventable injury.
4. Participation People's right to choice, decision making and to actively participate as a valued member of their chosen community is promoted and upheld.	4.1 People exercise choice and control in service delivery and life decisions.
	4.2 People actively participate in their community by identifying goals and pursuing opportunities including those related to health, education, training and employment.
	4.3 People maintain connections with family and friends, as appropriate.
	4.4 People maintain and strengthen connection to their Aboriginal and Torres Strait Islander culture and community.
	4.5 People maintain and strengthen their cultural, spiritual, and language connections.
	4.6 People develop independent life skills.

Source: DHS 2011g, p. 4.

Table 4 Principles of good governance of regulators

Role clarity	
Objectives	1 The objectives of the legislation establishing a regulatory scheme and the purpose of the regulator should be clear to the staff, regulated entities and the community.
Functions	2 Regulatory and other functions to meet the objectives should be specified in the establishing legislation. 3 The assignment of potentially conflicting functions to any regulator should only occur if there is a clear public benefit in combining these functions and the risks of conflict can be managed. 4 Where a regulator is given potentially conflicting functions, there should be a mechanism whereby conflicts arising are made transparent and processes for resolving such conflicts are specified. 5 The primary responsibility for assisting the Minister to develop government policy should sit with the Minister's department. Such policy should be advanced in close dialogue with affected regulatory and other agencies.
Coordination	6 All regulators should be explicitly empowered to cooperate with other bodies (non-government and State, Commonwealth and local government) where this will assist in meeting their common objectives. 7 Instruments for coordination between entities, such as memoranda of understanding, formal agreements or contracts for service provision, should be published on regulators' websites, subject to the appropriate removal of information (for example, that which is commercial-in-confidence).
Degree of independence	
Independence	1 Independent regulatory decision-making, at arm's length from Ministers and their departments, is likely to be appropriate where: there is a need for the regulator to be seen as independent, to maintain public confidence; the decisions of the regulator can have a significant impact on particular interests and there is a need to protect its impartiality; significant enforcement activities are performed; or both government and private entities are regulated under the same scheme. 2 Where the regulatory function appropriately sits within a department and structural separation of regulatory functions from other departmental programs is not practicable or is undesirable for other reasons, the degree of independence for departmental regulators should be supported by their empowering legislation. 3 All regulators work within the power delegated by Parliament and remain subject to government policy.
Protecting independence	4 Where the legislation empowers the Minister to give general direction to an independent regulator, any direction provided should be documented and published. 5 Any communication between the Minister, his or her department and an independent regulator should occur in a way that does not compromise the actual or perceived independence of regulatory decision-making. 6 The provisions relating to the termination of the appointments of members of a regulator's governing body should be explicit.
Decision-making and governing body structure for independent regulators	
Decision-making model	1 The appropriate governing body structure should be determined by the nature of the regulated activities and the regulation being administered, including its level of risk, degree of discretion, level of strategic oversight required and the importance of consistency over time.
Relationship between the responsible Minister, governing body and CEO	2 There should be a clear allocation of decision-making and other responsibilities between the responsible Minister, the governing body and the CEO or individual in charge of the organisation's performance and implementation of decisions. 3 Where there is a multi-member governing body, the CEO or individual responsible for managing the organisation's performance and implementing regulatory decisions should be primarily accountable to, but not a member of, the governing body.
Membership of the governing body	4 Where there is a need for formal representation of specific stakeholders, this should be addressed through the establishment of an advisory or consultative committee rather than through membership of the regulator's governing body. 5 Departmental representatives should only participate in meetings of the governing body of independent regulators in a non-voting capacity.

	6 The role of members of the governing body who are appointed for their technical expertise or industry knowledge should clearly be to support robust decision-making in the public interest, rather than to represent stakeholder interests. 7 Policies, procedures and criteria for selection and terms of appointment of the governing body should be documented and readily available.
Accountability and transparency	
Accountability	1 Each Minister should outline in writing their expectations of each of their portfolio regulators. These expectations should be published with the relevant agency's corporate plan. 2 Regulators are accountable to Parliament through their Ministers and should report regularly through their Ministers on the fulfilment of their objectives and the discharge of their functions, including through a comprehensive set of meaningful performance indicators.
Transparency	3 Key operational policies and other guidance material, covering matters such as compliance, enforcement and decision review, should be publicly available.
Review of decisions	4 Regulators should establish and publish processes for arm's-length internal review of significant delegated decisions. 5 The opportunity for independent review of significant regulatory decisions should be available in the absence of strong public policy reasons to the contrary.
Engagement	
Fit for purpose	1 Regulators should undertake regular and purposeful engagement with the regulated and other stakeholders focused on improving the operation and outcomes of the regulatory scheme.
Avoiding capture and conflicts of interest	2 Engagement processes used should protect against potential conflicts of interests of participants and guard against the risk that the regulator may be seen to be captured by special interests.
Funding	
Supports outcomes efficiently	1 Funding levels should be adequate to enable the regulator, operating efficiently, to effectively fulfil the objectives set by government, including obligations imposed by other legislation. 2 Funding processes should be transparent, efficient and as simple as practicable.
Regulatory cost recovery	3 Any cost-recovery fees should be set by the Minister in accordance with policy objectives and the Department of Treasury and Finance (DTF) Cost Recovery Guidelines.
Litigation and enforcement costs	4 Regulators should have a defined process to obtain funding for major unanticipated court actions in the public interest that is consistent with the degree of independence of the regulator.
Funding of external entities by a regulator	5 A regulator should only fund other entities to deliver activities directly related to the regulator's objectives, such as information and education about how to comply with the regulation. 6 Any funding of representative or policy advocacy organisations should be the responsibility of the relevant portfolio Minister's department, not the regulator.

Source: Department of Premier and Cabinet 2010

Table 5 Functions and powers of commissioners for children and child guardians, selected Australian jurisdictions

Victoria	New South Wales	Queensland
Name		
Child Safety Commissioner	Commission for Children and Young People	The Children's Guardian
Appointment		
Commissioner employed as a public servant	Commissioner appointed as an independent statutory officer by the Governor	Guardian appointed as an independent statutory officer by the Governor
Monitoring responsibilities		
Monitors the performance of out of home care services	Monitors the overall safety, welfare and wellbeing of children Monitors trends in complaints made by or on behalf of children Monitors training, public awareness activities and research on issues affecting children	No monitoring responsibilities
Advocacy responsibilities		
Promotes child-friendly and child-safe practices in the Victorian community Promotes the provision of out of home care services that encourage the active participation of those children in the making of decisions that affect them	Promotes the participation of children in the making of decisions that affect their lives and encourages government and non-government agencies to seek the participation of children appropriate to their age and maturity Promotes the overall safety, welfare and well-being of children in the community Promotes the provision of information and advice to assist children Conducts and promotes training, public awareness activities and research on issues affecting children Encourages organisations to develop their capacity to be safe and friendly for children	Promotes the best interests of all children and young persons in out-of-home care Ensures that the rights of all children and young persons in out-of-home care are safeguarded and promoted

South Australia	Western Australia	
Name		
Commission for Children and Young People and Child Guardian	Guardian for Children and Young People	Commissioner for Children and Young People
Appointment		
Commissioner appointed as an independent statutory officer by the Governor-in-Council	Commissioner appointed as an independent officer by the Governor	Commissioner appointed as an independent statutory officer by the Governor
Monitoring responsibilities		
Monitors the systems, policies and practices of the child safety department and other service providers that affect children in the child safety system Monitors the handling of individual cases of children in the child safety system Monitors the department's compliance with its statutory responsibilities when placing Aboriginal and Torres Strait Islander children in care Monitors laws, policies and practices that relate to the delivery of services to children, or otherwise impact on children	Monitors the circumstances of children under the guardianship, or in the custody, of the Minister	Monitors the wellbeing of children and young people generally Monitors the way in which government agencies respond to complaints made by a child or young person and the outcomes of the complaint Monitors trends in complaints made by children to government agencies
Advocacy responsibilities		
Advocates for children and, in advocating for children, seeks help from advocacy entities, service providers and other entities Promotes the establishment by service providers of appropriate and accessible mechanisms for the participation of children in matters that may affect them Promotes awareness among children about advocacy entities, complaints agencies and other relevant entities Promotes an understanding of, and informed public discussion about, the rights, interests and wellbeing of children	Promotes the best interests of children under the guardianship, or in the custody, of the Minister, and in particular those in alternative care Advocates for the interests of children under the guardianship, or in the custody, of the Minister and, in particular, for any such child who has suffered, or is alleged to have suffered, sexual abuse	Advocates for children and young people Promotes the participation of children and young people in the making of decisions that affect their lives and encourages government and non-government agencies to seek the participation of children and young people appropriate to their age and maturity Promotes and the wellbeing of children and young people generally Promotes public awareness and understanding of matters relating to the wellbeing of children and young people Conducts, coordinates, sponsors and promotes research into matters relating to the wellbeing of young people

Table 5 Functions and powers of Commissioners for Children and Child Guardians, selected Australian jurisdictions (continued)

Victoria	New South Wales	Queensland
Proirity Groups		
The Commissioner's functions have a focus on children in out-of-home care	Must give priority to the interests and needs of vulnerable children	The Guardian's functions have a focus on children in out-of-home care
Investigation and inquiry powers		
At the request of the Minister, may investigate an out of home care service or conduct an inquiry in relation to a child protection client	If required to do so by the Minister, may inquire into a specified issue affecting children	None
Special reports		
No provision to make special reports	May report on any issue or matter relating to the Commission's functions	May report on any issue or matter relating to the functions of the Guardian
Where reports are submitted		
Annual reports submitted to Minister and Parliament	Minister and Parliament	Minister and Parliament
Oversight		
No special arrangements	A Parliamentary Joint Committee monitors and reviews the Commission's exercise of its functions	No special arrangements

South Australia	Western Australia	
Proirity Groups		
Must give priority to the needs and interests of children who: • Are in, or may enter, out-of-home care or detention in a detention centre; • Have no appropriate person to act on their behalf; • Are not able to protect their rights, interests or wellbeing; or • Are disadvantaged because of a disability, geographic isolation, homelessness or poverty	Must pay particular attention to children under the guardianship, or in the custody, of the Minister who have a physical, psychological or intellectual disability	Must give priority to the interests and needs of Aboriginal and Torres Strait Islander children and young people and children and young people who are disadvantaged or vulnerable for any reason
Investigation and inquiry powers		
May investigate matters relating to services provided to children in the child safety system	May inquire into and provide advice to the Minister in relation to systemic reform necessary to improve the quality of care provided for children in alternative care	May inquire into any matter affecting the wellbeing of children and young people
Special reports		
May report on matters relating to the Commissioner's functions	May report on any matter relating to the Guardian's functions	May publish information on matters relating to the Commissioner's functions
Where reports are submitted		
Minister and Parliament	Minister and Parliament	Minister and Parliament
Oversight		
No special arrangements	No special arrangements	A Parliamentary Joint Committee may request the Commissioner to consider any matter relating to the wellbeing of children and young people

Table 6 Governance arrangements for selected Victorian Commissions

Essential Services Commission	Transport Accident Commission	Victorian Commission for Gambling Regulation	Victorian Competition and Efficiency Commission
Legal status			
Independent statutory body Represents the Crown	Independent statutory corporation	Independent public authority Represents the Crown	Independent statutory body
Powers			
Can do all things necessary or convenient to be done for or in connection with the performance of its functions	Can do all things necessary or convenient to be done for or in connection with the performance of its functions and to enable it to achieve its objectives	Has all the powers necessary to perform its functions and achieve its objectives	Can do everything necessary or convenient to be done for, or in conjunction with, the performance of its functions, other than appoint staff
Relationship with Minister			
The Minister may request the Commission to conduct an inquiry into any systemic reliability of supply issues related to a regulated industry or other essential service The Commission is not subject to the direction or control of the Minister	The Commission must perform its functions and exercise its powers subject to (among other things) the general direction and control of the Minister	No relationship specified in legislation	The Minister may request the Commission to conduct an inquiry into any matter
Membership			
The Commission consists of a Chairperson and such number of full-time and part-time additional Commissioners as the Minister considers necessary to enable the Commission to perform its functions	The Commission has a Board of Management that consists of not less than four, and not more than nine, Directors	The Commission consists of: a commissioner appointed as Chairperson; one or more commissioners appointed as Deputy Chairpersons; a commissioner appointed as Executive Commissioner; and as many additional commissioners and sessional commissioners as the Minister considers necessary to enable the Commission to perform its functions	The Commission consists of a commissioner appointed as Chair and between two to four additional commissioners
Appointment of Commissioner			
Appointed by Governor-in-Council	Appointed by Governor-in-Council on the nomination of the Minister	Appointed by Governor-in-Council on the recommendation of the Minister	Appointed by Governor-in-Council

Victorian Equal Opportunity and Human Rights Commission	Victorian Law Reform Commission	Victorian Multicultural Commission
Legal status		
Independent statutory body	Independent statutory body	Independent statutory body Represents the Crown
Powers		
Has all the powers necessary to enable it to perform its functions	With the exception of certain limits on its powers to acquire, dispose of or lease property, can do all things necessary or convenient to be done for, or in connection with, performing its functions	Can do all things necessary or convenient to be done for, or in connection with, carrying out its objectives and performing its functions
Relationship with Minister		
No relationship specified in legislation	No relationship specified in legislation	The Minister may give written directions to the Commission in relation to the performance of its functions
Membership		
The Commission has a Board consisting of not more than seven members A Commissioner is appointed by the Board with the approval of the Minister	The Commission consists of a Chairperson and such number of full-time and part-time additional Commissioners as the Governor-in-Council considers necessary to enable the Commission to perform its functions	The Commission consists of 12 members, including: a Chairperson; a Deputy Chairperson; a youth representative; and a representative of a community organisation
Appointment of Commissioner		
Appointed by Governor-in-Council on the recommendation of the Minister	Appointed by Governor-in-Council	Appointed by Governor-in-Council on the recommendation of the Minister

List of abbreviations

A

AAV	Aboriginal Affairs Victoria
ABS	Australian Bureau of Statistics
ACOSS	Australian Council of Social Services
ACCO	Aboriginal community controlled organisation
ACPP	Aboriginal Child Placement Principle
ACSASS	Aboriginal Child Specialist Advice and Support Services
AEDI	Australian Early Development Index
AER	Foundation Alcohol Education and Rehabilitation Foundation
AFDM	Aboriginal Family Decision Making
AFVPLSV	Aboriginal Family Violence Prevention and Legal Service Victoria
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
ADR	appropriate or alternative dispute resolution
ADYC	alcohol and drug youth consultant
ALRC	Australian Law Reform Commission
ANCD	Australian National Council on Drugs
ANF	Australian Nursing Federation
AOD	alcohol and other drugs

B

BCG	Boston Consulting Group

C

CAMHS	Child and Adolescent Area Mental Health Services
CASA	Centre Against Sexual Assault
CASEA	CAMHS and Schools Early Action Program
CASIS	Client and Service Information System
CAU	Court Advocacy Unit
CCCDP	Children's Court Clinic Drug Program
CCS Act	*Children and Community Services Act 2004*
CDI	Child Death Inquiry
Charter Act	*Charter of Human Rights and Responsibilities Act 2006*
Child FIRST	Child and Family Information, Referral and Support Teams
CHS	community health services
COAG	Council of Australian Governments
CPP	child protection practitioner
CPS	Children's Protection Society
CPSU	Community and Public Sector Union
CPL Office	Child Protection Litigation Office

CPW	child protection worker
CRC	Convention on the Rights of the Child (United Nations)
The Charter Act	*Charter of Human Rights and Responsibilities Act 2006 (Vic)*
The Children's Court	Children's Court of Victoria
The Clinic	Children's Court Clinic (Victoria)
The Coroners Court	Coroners Court of Victoria
The County Court	County Court of Victoria
Crimes Act	*Crimes Act 1958*
CRIS	Client Relationship Information System
CRISSP	Client Relationship Information System for Service Providers
CSCB	Children's Services Coordination Board
CSO	Community service organisation
CSP	cultural support plan
CYP Act	*Children and Young Persons Act 1989 (Vic)*
Cwlth	Commonwealth
CWS Act	*Child Wellbeing and Safety Act 2005 (Vic)*
CYF Division	Children, Youth and Families Division of the Department of Human Services
CYF Act	*Children, Youth and Families Act 2005 (Vic)*

D

DAGJ	Department of Attorney-General and Justice (New South Wales)
DALY	disability adjusted life years
DCP	Department of Child Protection (Western Australia)
DEECD	Department of Education, Early Childhood and Development (Victoria)
DIAC	Australian Government Department of Immigration and Citizenship
DOH	Department of Health (Victoria)
DOJ	Department of Justice (Victoria)
DHS	Department of Human Services (Victoria)
DPC	Department of Premier and Cabinet (Victoria)
DPP	Director of Public Prosecutions (Victoria)
DRC	Dispute Resolution Conference in the Children's Court
DRM	Dispute Roundtable Management
DSCV	Disability Services Commissioner Victoria
DTF	Department of Treasury and Finance (Victoria)
DPCD	Department of Planning and Community Development

E

ECCV	Ethnic Communities Council of Victoria
EMCH	Enhanced Maternal and Child Health
ESC	Essential Services Commission
ESK	Early Start Kindergarten

F

FaPMI	Families where a Parent has a Mental Illness
FDH	Family Drug Help
FGC	family group conference
FL Act	*Family Law Act 1975 (Cwlth)*
FTE	full-time equivalent
FVP Act	Family Violence Protection Act 2008 (Vic)
FVPLS	Family Violence Prevention Legal Services

G

GP	General Practitioner

H

HSPIC	Human Services Partnership Implementation Committee
HSS	Humanitarian Settlement Services

I

ICWA	*Indian Child Welfare Act 1978 (United States)*
IFS	Integrated Family Services
IWDVS	Immigrant Women's Domestic Violence Service

K

KMS	Koori Maternity Service

L

LAT	Less Adversarial Trial
LAWA	Legal Aid Western Australia
LGA	local government area
LGV	Local Government Victoria
LIV	Law Institute of Victoria

M

MAC	Mildura Aboriginal Corporation
MACS	Multi-functional Aboriginal Children Services
MAV	Municipal Association of Victoria
MCH	maternal and child health
MDC	Multidisciplinary Centre
MV Act	*Multicultural Victoria Act 2011*

N

NAPCAN	National Association for the Prevention of Child Abuse and Neglect

NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NFP	not-for-profit organisation
NGO	non-government organisation
NMC	New Model Conference
NSWLRC	New South Wales Law Reform Commission

O

OECD	Organisation for Economic Co-operation and Development
OCSC	Office of the Child Safety Commissioner (Victoria)
OPA	Office of the Public Advocate (Victoria)
OPP	Office of Public Prosecutions (Victoria)
OOHC	Out-of-home care

P

PANDA	Post Antenatal Depression Association
PRISM	Prosecution Recording and Information System
PSIO	Personal Safety Intervention Order
PSNP	Primary School Nursing Program

Q

QEC	Queen Elizabeth Centre
QUT	Queensland University of Technology

R

RCH	Royal Children's Hospital
RCLDS	Residential Care Learning and Development Strategy
RDM	Roundtable Dispute Management
RMF	Regional Management Forum
ROGS	Review of Government Services

S

SAC	Sentencing Advisory Council
SCAG	Standing Committee of Attorneys General
SCHN	Sydney Children's Hospital Network
SCRGSP	Steering Committee Review of Government Service Provision
SEHQ	School Entrant Health Questionnaire
SEIFA	Socio-Economic Indexes for Areas
SOCAU	Sexual Offences and Child Abuse Unit
SOCIT	Sexual Offences and Child Abuse Investigation Team
SOR Act	Sex Offenders Registration Act 2004

SOS	Signs of Safety (Western Australia)
SPPI	Supported Playgroups and Parent Group Initiative
SSO Act	Serious Sex Offenders (Detention and Supervision) Act 2009

T

The Taskforce	Child Protection Proceedings Taskforce

U

UNICEF	United Nations Children's Fund

V

VAADA	Victorian Alcohol and Drug Association
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VAGO	Victorian Auditor-General's Office
VCAMS	Victorian Children and Adolescent Monitoring System
VCAT	Victorian Civil and Administrative Tribunal
VCC	Victorian Children's Council
VCEC	Victorian Competition and Efficiency Commission
VEOHRC	Victorian Equal Opportunity and Human Rights Commission
VFPMS	Victorian Forensic Paediatric Medical Service
VIAF	Victorian Indigenous Affairs Framework
VLA	Victoria Legal Aid
VACCA	Victorian Aboriginal Child Care Agency
VACSAL	Victorian Aboriginal Community Services Association Ltd
VALS	Victorian Aboriginal Legal Services Cooperative Ltd
VCDRC	Victorian Child Death Review Committee
VCOSS	Victorian Council of Social Services
VGSO	Victorian Government Solicitor's Office
VLRC	Victorian Law Reform Commission
VMC	Victorian Multicultural Commission
VPS	Victorian Public Service
VSC	Victorian Supreme Court

W

WWC	Working with Children Check
WWC	*Working with Children Act 2005*

Y

YAC	Vic Youth Affairs Council of Victoria
YSAS	Youth Support and Advocacy Service

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