Individual submission

Introduction

This represents an individual submission from Bernadette Burchell, drawing on experience as a worker and manager in child and family welfare services for over 15 years, including foster care, family support services, early childhood and therapeutic services, including from 2005-2010 as Chief Executive Officer of the Children's Protection Society in Victoria, and with post graduate qualifications in human services management and a Master of Social Work from Latrobe University.

The care and protection of children is a family and social responsibility and I welcome the opportunity to provide comment to the Protecting Victoria's Vulnerable Children Inquiry

I have provided comment on questions and issues where my experience is recent and relevant.

1. The factors that increase the risk of abuse and neglect occurring, and effective preventive strategies.

1.1 Given the different forms which child abuse and neglect may take, and the very broad range of risk factors involved (for example, parental substance misuse, domestic violence, socio-economic stress, inadequate housing, availability of pornography, parental history of child maltreatment, poor parent-child attachment, social isolation etc):

1.1.1 What are the key preventive strategies for reducing risk factors at a whole of community or population level?

- Reducing family violence
- Reducing social isolation- ensuring participation of vulnerable parents in ante natal care, new parents support groups, child care services, community services
- Reducing parental alcohol and substance use and abuse
- Reducing socio economic stress – access to affordable housing in child and family friendly communities, access to affordable nutritious food, parental economic, education and social participation
- Successful engagement of children in education
- Increasing parental knowledge and shills about early years brain development, responsive care giving and child development – ante natal birthing services and maternal and child health service as the platform
- Parental access to education and skills development, child care, respite, shared parenting support, timely extra support when needed
- Promotion of children as having rights to safety, wellbeing, and services in their own right

1.1.2 What strategies should be given priority in relation to immediate, medium and longer term priorities?

Infancy (0-3 years) and early childhood (0-8 years) focused strategies that ensure the participation of vulnerable children and families in high quality intense services that deliver the outcomes of healthy early childhood development and responsive parenting should be given immediate priority.

The early years are an unparalleled window of opportunity to get the ingredients right for healthy children and families.

Children who are identified as at risk should be enrolled into participation into all the activities and services that a good parent would access for their children- antenatal services, immunisation, pre-school reading, playgroups, parent education, and have access to a home environment that supports their healthy development.

When children do not have access to a quality home environment, immediate priority should be given to providing the supplementary and complementary care that will compensate for or mediate the impacts of low quality parental care.

This is a critical strategy to start to break the cycle of disadvantage that arises from parental neglect.

Funding to access quality intense early years care and education as an intervention should be in the case mix for children at risk in Victoria, matching immediately the NSW investment of 20 hours of child care per week , and building models of intervention in Victoria that engage significantly disadvantaged families and ensure better child development outcomes for infants at risk.

The SDN Children's Services model in NSW that has community based quality children's centres reaching out to include and support disadvantaged families to participate in using centre based child and family services in their own neighbourhoods is a demonstrably effective model that could be replicated in Victoria.

1.1.3 What are the most cost-effective strategies for reducing the incidence of child abuse in our community?

Strategies that are successful in engaging and sustaining the participation of vulnerable or at risk children and families in interventions that have a strong evidence base as effective (in reducing risk factors or increasing protective factors) are the most cost effective.

It is my experience that it is often the case that those who are most in need of quality services are those who are least likely to be able to access them when they need them for the intensity and duration that they need them to make an impact on the problem.

Participation of the whole community in activities that are known to be good for children and families, with funding to assure additional remedial, therapeutic or compensatory services tailored to reducing risk for vulnerable children and families is the most cost effective strategy to reduce the incidence of child abuse in the community.

A focus on improving outcomes in early years parenting skills and child development will contribute significantly to medium and longer term impacts on child abuse.

1.1.4 Do the current strategies need to be modified to accommodate the needs of Victoria's Aboriginal communities, diverse cultural groups, and children and families at risk in urban and regional contexts?

Aboriginal children are over represented in the tertiary end services of child protection and out of home care and under represented in primary care and universal services.

This situation needs to be reversed, with full participation in universal services that are known to be good for children and families and funded access to additional culturally safe remedial, therapeutic or compensatory services tailored to reducing risk factors for child abuse (one of which is racial discrimination) and increasing protective factors (one of which is pride in culture)

Cultural safety is an important experience to assure to support participation of children and families from diverse cultural backgrounds.

1.1.5 Some in the sector have argued for the introduction of a 'Public Health Model' in relation to child protection. What might be the benefits of introducing such a model in Victoria? What are the main characteristics of such a model?

Child abuse figures strongly in the histories of adults with mental health problems and substance abuse issues, as well as in the histories of those who are imprisoned for crimes of violence.

The public health model focuses on the determinants of health and in this model reducing the incidence of child abuse will reduce burden of disease and health and justice costs down the road.

The public health model focuses on reducing the incidence of, for example, parental alcohol use and abuse, a known determinant of child abuse, and therefore reduce the incidence of child abuse.

The benefits of such a model are in the focus on prevention i.e. reducing the actual incidence of child abuse, and as a framework for investment in prevention strategies, and assuring some balance in priorities between prevention, early intervention and “after the fact” remedial interventions.

The main characteristics of the public health model would be :

- An expanded concept of child protection to include universal and secondary services such as maternal and child health services, birthing services, immunisation services, parenting groups, playgroups, kindergartens, counselling, casework, case management services, as well as tertiary end statutory services
- Population level strategies to achieve e.g. full participation in ante natal care, immunisation, maternal and child health ages and stages visits
- Promotion of healthy child and family behaviour
- Greater emphasis on prevention and early intervention
- Greater focus on indicators of relevance to child wellbeing – not just reports to child protection
- Greater focus on research and development in prevention and early intervention strategies
- A business case for funded services in terms of the expected impact on child abuse e.g. Program logic that states the indicator that the activity is expected to impact upon
- Hope, optimism, and evidence that the problem of child abuse can be reduced – a belief that it’s not hopeless, it’s not a bottomless pit for resources, and given the impact of child abuse on community burden of disease, a public health approach has merit.

2. Strategies to enhance early identification of, and intervention targeted at, children and families at risk including the role of adult, universal and primary services. This should include consideration of ways to strengthen the capability of those organisations involved.

2.1 What is the appropriate role of adult, primary and universal services in responding to the needs of children and families at risk of child abuse and neglect? Please provide comment in relation to any of the services listed below or any additional services that you regard as relevant to this Term of Reference.

2.1.1 Universal and primary children’s services such as general medical practitioners, antenatal services, maternal and child health services, local playgroups, early childhood education and care services, primary schools, secondary schools, and telephone and internet based services for children and young people seeking information and support.

These services are part of the “village” it takes to raise a child.

Their role is to

- Be user friendly to vulnerable children and their families
- Support engagement and participation in all the services and activities that are good for children and families
- Notice children, and engage with them directly , engage in conversations with parents about their children
- Be alert to indicators of unacceptable risk to the safety and wellbeing of children
- Make referrals to extra services, and support engagement of parents and children with those services
- Get the support they need to better include and sustain the participation of vulnerable children and families, through service partnerships, through professional development and training, through extra staff or staff with relevant expertise.

They should be held to account for their responsibility to provide services for vulnerable children and families as part of their brief as universal services.

In my experience I have observed there can be a tendency to exclusion of children and families that are difficult to include, or more expensive to include.

2.1.2 Targeted child and/or family services such as enhanced maternal and child health services, children's disability services, specialist medical services, child and adolescent mental health services, family support services, family relationship counselling services and Aboriginal managed health and social services.

Targeted services are specialists.

Their role is to:

- Develop models of service that are acceptable to vulnerable families
- Develop the skills and abilities or adjustments of universal services so the "vulnerable: can fit in and participate successfully.
- "Treat" the problem in which they specialise and produce the outcomes or the progress on indicators that their speciality indicates, and that universal services can't be expected to be able to provide
- Design experiences of services for their clients to practice successful participation and get a taste for the benefits of the experience of participation e.g. counselling, playgroups, social groups, recreation services, child care, kindergarten
- Ensure families are linked in successfully with community services before withdrawing , being available to back it up if things go awry , re-engage
- Form partnerships with universal, be a bridge for vulnerable families to community participation
- Be part of the ongoing care team- providing secondary consultation, shared care, outreach, in-reach

I note that Child Protection Service isn't mentioned here and yet they are a specialist service as well, and the above applies equally.

2.1.3 Specialist adult focused services in the field of drug and alcohol treatment, domestic violence, mental health, disability, homelessness, financial counselling, problem gambling, correctional services, refugee resettlement and migrant services.

Their role is to "treat" the problem in which they specialise and produce the outcomes or the progress on indicators that their speciality indicates.

Their client is the adult. Where there are dependents, the service has a duty of care to those dependents, who will most certainly be impacted upon by the behaviour of the adult client.

I have observed that what often happens is that crisis is commonplace and prolonged, with families sometimes regarded as in perpetual crisis, and in these families the child's needs for stability, secure attachment , lack of stress, and engagement with others and community can be lost in the crucial early years of life.

Adult services workers need to attend to the integration and stability needs of children, and the safety and wellbeing of the primary carer

Adult services need education and training about child development and risk and protective factors to exercise their duty of care with respect to dependent children of clients.

They need to raise the profile of children in their assessment and care planning processes with clients who are parents, i.e they need to "think child" –they need to inquire about dependent children, ask to see them on home visits, inquire about child care arrangements when attending appointments, when in residential services, provide child friendly environments for children as visitors, include child development and parenting training in therapeutic and rehabilitation programs, encourage participation in community based parenting and children's services.

If adult services are providing services such as child care, or family support, then the same standards that apply to these services in the community need to apply to the quality of care provided through these services, eg family welfare organisations that are providing child care need to have high quality standards- vulnerable children require the best of what services have to offer, and the highest standards.

Good practice in adult services should include:

- Compulsory training in child development and risk and protective factors for children

- Assessment and care planning that takes full account of dependent children
- Recognition that parents in situations of stress may not be in a position to act in the best interests of their children, and another person may need to be assigned to represent the interests of the child in the casework process
- Caseworkers explicitly considering how a good parent would behave, or what they would do if it were their own child, and ensuring that this is what happens for children
- Child and family friendly policies, procedures and facilities
- Inclusion of improved parenting as a casework goal
- Design of experiences of services for their clients to practice successful participation and get a taste for the benefits of the experience of participation eg counselling, playgroups, social groups, recreation services, child care, kindergarten
- Ensuring families are linked in successfully with community services before withdrawing , being available to back it up if things go awry , re-engage
- Forming partnerships with universal and secondary level services, being a bridge for vulnerable families to community participation
- Being part of the ongoing care team- providing secondary consultation, shared care, outreach, in-reach

2.2 How might the capacity of such services and the capability of organisations providing those services be enhanced to fulfill this role?

- Education and training
- Specialist role within the organisation for “think child” policies and activities
- “Think child” as a required quality improvement initiative in adult services in mental health, alcohol and drug treatment services, family violence services, and housing support services,

2.3 What strategies should be given priority in relation to immediate, medium and longer term priorities?

- “Think Child” initiatives /pilots between Child FIRST providers and specialist adult services in Child FIRST catchments to improve the capacity of adult services to be aware of children at risk and respond appropriately

2.4 What are the most cost-effective strategies to enhance early identification of, and intervention targeted at, children and families at risk?

- Increasing the capacity of existing services to be aware (in assessment and intake phases) and respond (care planning for dependents, care team approach/shared care with family support services)

- Provision of case management through family services to develop a care team approach with at risk families
- Family support services- the development of a partnership fro change between a parent and the service provider , the setting and achievement of goals

3. The quality, structure, role and functioning of: family services; statutory child protection services, including reporting, assessment, investigation procedures and responses; and out-of-home care, including permanency planning and transitions; and what improvements may be made to better protect the best interests of children and support better outcomes for children and families.

3.1 *Over recent years Victoria has been developing an increasingly integrated service delivery approach to the support of vulnerable children and families. From a systems perspective what are the strengths and weaknesses of this approach?*
How should any identified weaknesses be addressed?

Having been integrally involved in a leadership capacity in the Family Support Innovation Pilot in Darebin in 2004, Darebin Integrated Family Services (DIFS) and then the establishment of Child FIRST North East Metro in 2007 I can say that the system is better now for vulnerable children and families than it was before 2004.

Pre 2004, a vulnerable family could be sitting on the wait list of several different family support services, being considered by each service within its own assessment, intake and priority allocation processes, operating as a “silo” in relation to other services..

The community care system did not have a means of assertively or accountably ensuring access to family support services for children at risk and there was a low level of mutual accountability between services to meet demand for services and to act as a coherent service system.

Child FIRST and the Child and Family Services Alliances have delivered on these improvements.

A weakness in the system is that the introduction of Child FIRST has not resulted in Child FIRST as the first point of contact for reporting vulnerable children to a service system that could assist them with family support and other community supports. This means that large numbers of children and families are still unnecessarily being brought to the attention of statutory services, who are less able than a community based service to meet their needs.

It seems to be that case that mandated professionals are continuing to report to Child Protection rather than make a Child Wellbeing Report to Child FIRST.

Data generated at the front door of child protection indicates that the vast majority of reports do not warrant child protection intervention i.e it is the “wrong door” .

There is a case for the “door” to the system of intervention for the protection and wellbeing of children to be shifted assertively out to the community, with Child FIRST significantly bolstered with investment in staff to provide the gateway to the broader child protection system, and clear pathways to action from the child protection service for children in need of protection.

This would see transfer of resources from statutory child protection intake to community based intake, and Child FIRST as the point of first response for reports from mandated professionals and the broader community.

Under such an arrangement Child fIRST comes to represent the threshold for community and non-statutory services. Statutory child protection services would accept referrals for investigation from Child FIRST and act as the default mechanism for the community child protection system .

The vision is for a broad system of responsibility for the protection of children with statutory intervention as a last resort.

Victoria is fortunate to have a well developed and capable non-government community child and family welfare services system capable of successfully delivering information, assessment, referral, case management , family support, out of home care, and therapeutic services in the child protection system, and enjoy a greater level of broad community support and engagement in doing so than is possible for a government service.

The future should be one where the statutory child protection system narrows in scope, specialising in producing good outcomes for children where statutory intervention is required, Child FIRST broadens in scope to be the front door to the broader community child protection system, the filter through which most referrals for statutory child protection intervention are processed, and the non-government child and family welfare services are resourced and supported to do all that is within their capabilities to do in the care and protection of children.

The community care system in Victoria at present is under developed in being able to provide the diversity, intensity and duration of community support needed to supplement and complement low quality parenting and sustain vulnerable children successfully in the

community , ensuring that they have the same opportunities to thrive as their better nurtured peers.

The community child care system needs to be significantly developed to include and sustain the participation of vulnerable children and families. Schools similarly need such support.

There are also opportunities to develop informal support in the community for vulnerable children and families through volunteer programs , enriching the experiences of family and community life and the web of connections that make up the “village it takes to raise a child” .

3.2 Providing a quality service to vulnerable children and their families is dependent on having a skilled workforce. What are the strengths and weaknesses of current workforce arrangements eg working conditions, training and career paths? How might any weaknesses be addressed?

a. Family services

3.3 What are the strengths and weaknesses of current services designed to assist families who are at risk of becoming involved in the statutory child protection system (for example ChildFIRST)?

A recent evaluation of Child FIRST and other reforms was undertaken by KPMG for the State Government. Child FIRST North East Metro was one of two sites to participate in the evaluation at a greater level of depth.

Overall Child FIRST is viewed as having strengthened the capacity of community care services to divert children and families in need from unnecessary progression into the child protection system.

I believe that the capacity for Child FIRST to accept Child Wellbeing reports (as an alternative to reporting to Child Protection), and priority allocations processes to this enhanced family support services program have resulted in significantly more intake to family support of cases with multiple risk factors than in the past, and sustained high demand from these higher risk families has increased specialisation of the family support program in the community care of high risk families with complex and intense support needs.

There needs to be the capacity to attract workforce for alcohol and drug treatment services and mental health services to work in the family support and child protection program. Many professionals from these services have a desire to make the transfer but the salary differential is too huge.

Family support and child protection work is highly skilled, therapeutic, practical, and requires a considerable "tool box " of knowledge and interventions for practitioners to draw on in the design and implementation of an agreed plan for change in vulnerable families.

Multi-disciplinary teams within and across organisations and specialities are required, and the funding and service agreements should recognise and support contemporary best practice models.

It should be noted that there is also a significant impost or overhead to "integrated service delivery" across several independent organisations in the time that senior and middle management must contribute to the effectiveness of the system in partnership processes, and particularly meetings.

The unit price for family services is not competitive in being able to recruit and retain a therapeutically skilled family support workforce and the management level skill and time required to work an effective integrated service system.

Family support services compete with child protection, alcohol and drug treatment services, mental health services, hospitals, community health and other services that are funded at a higher unit price to provide similarly skilled workforce.

3.3.1 How might the identified weaknesses be best addressed? Are there places where some of these services work more effectively than elsewhere? What appear to be the conditions associated with this and how might these conditions be replicated elsewhere in the State?

The recent KPMG evaluation should provide some insights into Child FIRST weaknesses and strengths and contributing conditions..

North East Metro Child FIRST is generally viewed as one of the more successful services and I provide a personal perspective on what has contributed to this success.

From the outset the leadership of the organisations that were funded to provide family support services in the catchment were fully engaged in the child welfare reforms and were in broad agreement with the direction of the reforms to build community capacity to divert unnecessary progression of vulnerable children into the child protection service.

There was and is well developed non-government child and family welfare service experience and capability in the north East catchment.

The Child FIRST North East integrated service arrangements built on a preceding 3 year State government funded pilot - Family Support

Innovations in Darebin, a partnership between four organisations that set up to provide integrated service delivery in one local government area.

This phase allowed the group of services to iron out many teething problems in integrated service delivery and to be able to scale up the catchment from one local government area to five local government areas, and the partnership from four organisations to nine organisations.

The leadership capabilities of DHS in the region, central office, and participating family support services was of a very high calibre, engaged in the task of collaboratively solving issues to deliver on the legislative requirement for a visible point of entry in the community to an integrated range of services to help vulnerable children and families.

The same leadership saw the initiative through its early stages of establishment, sorting out “teething issues” ,and managing unanticipated events, again with DHS senior leadership in the region as active partners in the process.

As the partnership has operated over time, and been successful, there has been a succession of leadership with many of the original organisations and the system seems to still work well, having harnessed all the state funded family support capacity on the catchment into a coordinated and accountable whole.

At this point it is worth providing some critical feedback about Child FIRST:

- The community sector did not receive enough resources to provide the level of services for highly vulnerable, “diverted from Child Protection” families.

Whilst there was an injection of resources into family services capacity with the advent of Child FIRST, it was from a low base.

In the North East Metro Child FIRST catchment of more than 500,000 people, there was an increase from approximately $3.2 million per year in family support funding to $4.3 million, supporting the establishment of a new service – Child FIRST, as an intake and referral service, with $250,000 per annum or 2.5 EFT staff, and an additional 10 or so full time family support caseworkers added to the existing family support workforce of 30 or so EFT employed by several organisations in the catchment.

I believe that the capacity for Child FIRST to accept Child Wellbeing reports (as an alternative to reporting to Child Protection), and priority allocations processes to this enhanced family support services program have resulted in significantly more intake to family support of

cases with multiple risk factors than in the past, and sustained high demand from these higher risk families has reduced the capacity of family support services to assist lower needs, earlier intervention cases.

Some unintended consequences I have observed include:

- A greatly increased level of referrals by professionals of vulnerable families to Child FIRST and family support as an alternative to Child Protection
- An under resourced and overwhelmed community information and intake system needing to restrict the volume of intake to family support services on several occasions in the first years of operation
- An under resourced and overwhelmed family support service system with a waiting period for service of months in many instances
- Possibly unrealistic expectations from DHS and the community about the capacity of community based intake/Child FIRST to manage the demand within the allocated resources
- Possibly unrealistic expectations of the impact that community based intake/Child FIRST would have on the volume of reports to Child Protection
- Increased specialisation of the family support program in the community care of high risk families with complex and intense support needs.
- Community perception of Child FIRST as community based child protection
- Reduced self referrals to family support by vulnerable families
- Reduced ability for family support services to work with universal services in prevention and early intervention strategies
- Significant demand pressures of high risk, high needs families on a “capped” level of community care resources
- Possibly negative impact of the Child FIRST “brand” for provider organisations

3.3.2 Is the overall structure of such services appropriate for the role they are designed to perform? If not, why and what changes should be considered?

The Child Protection Program in the DHS North and West region conducted a Change Laboratory in 2009 that involved a broad range of system stakeholders in considering how to improve the system and the program to get better outcomes for children, families and staff within existing funding, policy and legislative constraints.

I was involved in the process as a community service stakeholder and refer to the initiative here as it was a mini- review in some ways not dissimilar to the present review, and a cross-section of representatives of the regional child protection program came together to try and develop a way forward.

I refer to it here as one of the initiatives that was identified as high leverage in terms of impact on the child protection system was a system designed to ensure diversion away from child protection all those children and families for whom statutory intervention is not appropriate.

Keeping in mind that the two main outcomes from child protection reports are No Further Action, and Referral to Family Support, possibly indicating the public are approaching the wrong door for help.

In the design of this future thinking system, it was envisaged that Child FIRST would be the first point of contact for all children about whom there are wellbeing concerns, as the front door to the child wellbeing system including child protection.

The Child FIRST service would then refer to the statutory service system the cases that it assessed warranted investigation or statutory action.

Child protection would not maintain a front door role in taking reports. The result was envisaged to be far less demand at the front door for child protection and a better service for children and families in need.

It was also envisaged in this imagined new operating model for child protection, that there would be diversion from court into alternative dispute resolution processes, and a key role for child protection as case manager, contracting and funding intervention packages tailored to the assessed risk and protective factors to be addressed as the proposition is tested that the child is safe and well with community supports.

A transfer of the existing investment into child protection intake services to Child FIRST to operate this service would be required, and mandatory reporting obligations would need to be successfully acquitted through a report to Child FIRST.

As well there would need to be agreements about articulation into the statutory and timelines and standards for child protection response to Child FIRST referrals.

3.4.3 What has been the impact of the Victorian system of mandatory reporting on the statutory child protection services? Have there been any unintended consequences from the introduction of the Victorian approach to mandatory reporting and, if so, how might these unintended consequences be effectively addressed?

Mandatory reporting of child abuse was intended as a facilitator of community responsibility to identify and report child abuse, and a clear responsibility of the statutory system to respond to these reports.

By any calculation, a system that forecasts one in 20 children will be reported to child protection, is an over exposure of children to statutory services.

My direct experience and practice wisdom would put the figure of those children in the community who would meet the threshold for statutory intervention to ensure their safety and welfare in the realm of 1 or 2 per cent of the population, with prevalence being higher in neighbourhoods where there is a concentration of disadvantaged families.

Two thirds of reports to Child Protection are for neglect, and of these the vast majority are assessed as requiring no further action or referred to family support services.

I believe the community has different standards than the law with respect to what they believe is actionable with respect to the care and nurture of children. Also, in my view, the community has unrealistic expectations about what child protection can do with respect to the vast majority of reported families who do not meet the threshold for statutory intervention.

And all this in a media context that seems to believe that all child abuse is preventable, or that the child protection service is at fault if a child that has been reported subsequently meets with harm.

I believe that there is an unnecessarily high level of reporting to child protection of children in the community. I don’t know how many of these reports are from mandated professionals, and I don’t know whether mandatory reporting has achieved its original intent of ensuring children at risk are identified and responded to.

The experience of being reported to Child Protection can be a devastating one for vulnerable families, with the fact of someone reporting them eroding often fragile levels of trust in services with families subsequently withdrawing from services, falling out with important providers of support and care, and contributing to even greater stress in the family which elevates the risk environment for children.

Reporting to Child FIRST is an opportunity for concerned community members to bring vulnerable children and families to the attention of a service and assist in the engagement of vulnerable children and families in services that will address risk and protective factors and improve care and outcomes for children.

The feasibility of Child FIRST as the destination for all mandatory reports of child abuse should be considered.

Final comments

An improved child protection system in Victoria would see:

- A much broader definition of the child protection system than at present
- Significantly more investment in community care services for vulnerable children and families, particularly in early parenting and early years care and development services
- A plan for growth in government in community services based on population growth and greater government expectations of the community to act to protect children
- Significant support to universal services, particularly early childhood services and schools, to include and sustain vulnerable children and families
- The non-government sector properly resourced to take on the fullest possible role in child protection including screening , case management, casework and out of home care
- A targeted, well resourced and respected statutory child protection service , able to achieve good outcomes for vulnerable children and families , with an engaged and effective workforce
- A standard for all services that requires all of us to act as a good parent would , and to require from all who come into contact with vulnerable children the same that we would expect and require for our own children
- The state being responsible as a good parent would be for the continuing wellbeing of children leaving statutory care until age 21 years

Thank you for the opportunity to contribute to the review and my hopes for a resulting system that is the better for the review, and in which the Victorian community can be confident that vulnerable children are identified, supported, made safe and can thrive.

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