THE PROTECTING VICTORIA'S VULNERABLE CHILDREN INQUIRY

A Submission by the Children's Protection Society

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INTRODUCING THE CHILDREN'S PROTECTION SOCIETY

The Children's Protection Society (CPS) is a Victorian not-for-profit organisation. Our mission is "to break the cycle of abuse and neglect in families and to improve the life chances and choices for all children". Consistent with this child centred mission we provide services to children and their families, which aim to protect children from harm, and to remedy harm done to children as a result of neglect and abuse.

Founded in 1896 as the Victorian Society for the Prevention of Cruelty to Children, CPS is one of the oldest independent child welfare organisations in Victoria and holds a unique place in the history of both Victorian and Australian child protection.

Throughout its history, CPS has accumulated a distinguished record of leadership and innovation in the design and provision of integrated child protection services. CPS is unrelenting in its dedication to provide early intervention and effective support to Victoria's most vulnerable children. We provide counselling and support to children and families experiencing child maltreatment. CPS is also funded to provide counselling for children exhibiting sexually abusive behaviours, support services for first-time mothers, and men's programs specifically designed to generate better fathering within at-risk Victorian families.

CPS is well connected to other local organisations which provide services to vulnerable children and their families. We are the lead agency for the Victorian Government's *ChildFIRST* program in the north east region of Melbourne. We are building a continumum of care with the *Transitions Clinic* at the *Mercy Hospital for Women* through early interventions such as the *I'm an Aboriginal Dad* program and the *Mentoring Mums* project. Furthermore, through our *Child & Family Centre* we provide direct early childhood care and education to children at risk of deveopmental delays because of abuse and neglect.

CPS also has a focus on community practice with relationships and partnerships with *Banyule Community Health*, the *Northern Hospital*, *Noah's Arc Northern*, *Neighbourhood Renewal Projects*, and local governments, along with having a broad range of networks with groups concerned with breaking the cycle of abuse and improving opportunities for children.

In 2009-2010, CPS had an annual operating budget of $4.53m. We are governed by a board of management and have a staff of 50 comprised mainly of specialised professionals including social workers, child and family therapists, and counsellors.

CURRENT SERVICES PROVIDED BY THE CHILDREN'S PROTECTION SOCIETY

We provide ongoing services at two levels – (i) direct services to children and their families and (ii) leading the regional coordinated entry and referral service (viz., ChildFIRST North East).

(i) Direct services to children and their families:

Since 1896, CPS has provided services directly to children and families. These services currently include:

Community & Family Support Services: These services include in-home supports programs, parenting support programs and specialised fatherhood support programs. Together they are designed to offer a universal protection platform for the identification and support of vulnerable children, while striving to prevent the unnecessary progression of these children into the statutory child protection system. In 2009-2010, the achievements of Community & Family Support Services included:

- Providing 17,650 hours of support to 423 families;
- The provision of two supported playgroups for 45 young parents and 65 children in partnership with *Berry Street* and *Banyule Community Health Centre*;
- Supporting 132 children and their families in transition to school through the *Supporting Educational Engagement and Development Services* (SEEDS) program;
- Training 40 volunteers for the *Mentoring Mums* project, while supporting 20 ongoing volunteer-mum partnerships;
- Assisting 469 clients through the *I'm a Dad* and *I'm an Aboriginal Dad* programs, each of which aims to strengthen the role of men in family life;
- The provision of six community engagement sessions with the Somali community; and
- The provision of four support groups for parents and grandparents, which assisted 47 individuals to better nurture the children in their care.

Early Childhood Education and Care: Children and infants who are at-risk of maltreatment are also at-risk of developmental deficits that will compromise their life trajectories. These children are generally absent from early

childhood care and education services. Despite Victoria's high rate of state-funded pre-school enrolment (94%), many of the children involved in CPS's support programs (≥5 years of age) do not participate in any pre-school or early childcare services. This suggests that most of the 6% of Victorian children currently not enrolled in pre-school are children who suffer a significant risk for maltreatment. Consequently, the children most in need of high-quality early education and care services are those children least likely to participate in them.

The reason that at-risk children are absent from early childcare and education is complex, involving various circumstantial, systemic and structural barriers. Moreover, the problem is exacerbated by there being no model of care that is specifically devised to meet the needs of at-risk children. In response to this problem, CPS has worked with the Commonwealth Government, Victorian Government and philanthropic partners to establish an early childhood care and education pilot program at our *Child & Family Centre* in West Heidelberg. The pilot program targets at-risk children and their families and is designed to provide early childcare and education services within a wraparound model of family support.

In 2009-2010, the achievements of the Early Childhood Education and Care project included:

- Opening the CPS Child & Family Centre in February 2010, which provides five hours of care, five days per week, for the 20 children initially enrolled in the service; and
- The provision of 10,000 hours of childcare delivered at CPS Child & Family Centre.

Committed to best practice standards and evidence-based practice, CPS has also established an *Early Years Education Research Project*, which aims to evaluate the Child & Family Centre. The research project consists of a randomised controlled trial that will test the effectiveness of the Centre's model of care. It will conduct a rigorous social and cost benefit analysis of providing a centre-base childcare early intervention program aimed at breaking intergenerational cycles of abuse and neglect.

Counselling Services: Our team of psychologists and social workers provide an internationally recognised specialist therapeutic counselling service for children and young people who have been sexually abused. In addition, the service provides expert therapeutic interventions for children with sexualised behaviours and young people who have exhibited sexually abusive behaviours.

In 2009-2010, the achievements of the Counselling Service included:

- The provision of 6,712 hours of counselling for 277 sexually abused children and young people;
- The provision of 5,005 hours of treatment to 88 young people engaging in sexually abusive behaviours, with 18 young people completing treatment; and
- The provision of two long-term groups facilitated for young people who have engaged in sexually abusive behaviours.

Training and Community Education: We offer professional training and community education services in order to promote protective behaviours within in the family, raise community awareness about child maltreatment, and mobilise community action. We also offer specialised training and education programs that can be tailored to meet the needs of organisations charged with the care of children such as schools, residential care services, and foster care.

(ii) ChildFIRST North East:

Since 2007, CPS has been the agency responsible for operating ChildFIRST North East,[1] which a provides centralised intake service in the north-east metropolitan area. ChildFIRST North East assesses and refers at-risk children and their families onto nine regional family support services: Anglicare, Berry Street, Brotherhood of St Laurence, Children's Protection Society, City of Darebin, City of Yarra, North Yarra Community Health Centre, Kildonan Uniting Care and the Victorian Aboriginal Child Care Association. In 2009-2010, 1,981 families were assisted through Child FIRST, providing detailed assessments on 574 families, allocating 289 families for ongoing case management, undertaking 146 home visits and completing 363 consultations with Child Protection.

[1] Child and Family Information Referral and Support Team

INTRODUCING THE CURRENT SUBMISSION

CPS welcomes the opportunity to comment on the issues raised by the *Protecting Victoria's Vulnerable Children Inquiry*.[2] We believe that these issues are vital to improving the safety, health and wellbeing of all Victorian children and their families.

Protecting children and fostering their healthy development are amongst the most basic and indefeasible duties of any state. These duties arise from the unique developmental dependence of children, along with their inalienable possession of universal and child-specific human rights.[3] Moreover, a state's obligation to protect children entails a duty to foster physical and social environments that are conducive to healthy child development. While our child protection system strives to fulfil these duties and successfully guards and supports many Victorian children; nevertheless, CPS maintains that there are numerous aspects of the current system that are in urgent need of reform. In particular, the current system has all too often failed to avert the occurrence of preventable child maltreatment risk factors. Any health system that fails to reduce the cause and incidence of preventable diseases is a system that fails to fulfil one of its most basic functions. The same judgment holds true for any child protection system. Accordingly, CPS wishes to make a number of critical observations about the current system, while offering some suggestions on how to improve child protection outcomes.

The current submission will focus on areas where CPS believes our knowledge and experience enable us to make a valuable contribution. As such, our submission will respond to select issues outlined in numbers 1-6 of the Inquiry's terms of reference.

Finally, it should be noted that when the current submission uses the term 'child maltreatment' it intends not only the standard referents (viz., physical abuse, sexual abuse, neglect, and emotional abuse)[4] but also the witnessing of family violence[5] and bullying.[6]

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[2] Hereinafter referred to as the *Inquiry*.

[3] United Nations, "Convention on the Rights of the Child 1989", *Office of the United Nations High Commissioner for Human Rights* (OHCHR), http://www2.ohchr.org/english/law/crc.htm (8 September, 2010). [Hereinafter UN, *Convention on the Rights of the Child 1989*] See also *Charter of Human Rights and Responsibilities Act 2006* (Vic) s.17.

[4] See WHO, "Child Maltreatment," *World Health Organization*, 2010, http://www.who.int/topics/child_abuse/en/index.html (8 September, 2010).

[5] Rhys Price-Robertson and Leah Bromfield, "What is Child Abuse and Neglect?" No. 6 November 2009, *Australian Institute of Family Studies*, 2010, http://www.aifs.gov.au/nch/pubs/sheets/rs6/rs6.pdf (8 September, 2010).

A General Approach to Protecting Victoria's Children

The current submission commences with some general observations about the task of child protection. CPS maintains that Victoria's various efforts to protect children and prevent their maltreatment must be integrated within a broader *Child Safety, Health and Wellbeing Strategy*. A Victorian *Child Safety, Health and Wellbeing Strategy* would address the needs of the 'whole child' by integrating those various aspects of children's lives (e.g. health, education, safety, civic participation, and economic security, etc.) that have hitherto been treated separately by public policy.[7] As such, the strategy should emanate from the *Children's Services Co-ordination Board*.[8]

This policy integration is necessary for three reasons: (i) our duty to protect the welfare of children extends well beyond their mere protection from hurt and harm, (ii) the conditions necessary for optimising child safety are ultimately the same conditions necessary for optimising their healthy development, and (iii) Victoria should adopt both a *bioecological approach*[9] and a *public health approach*[10] to child protection planning and service provision. These allied approaches necessarily entail the development of an integrated, interdisciplinary, multi-modal and collaborative strategic platform.

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[6] See Australian Institute of Health and Welfare, *A Picture of Australia's Children 2009* (Canberra: AIHW, 2009), 107; and Evelyn Field, "Victims of Bullying and Post Traumatic Stress Disorder," *Australian Institute of Criminology*, 1999, http://www.aic.gov.au/events/aic%20upcoming%20events/1999/~/media/conferences/rvc/field.ashx (12 September, 2010).

[7] This accords with a *public health approach* to child maltreatment and shares an affinity with recent reforms to the United Kingdom's child protection system. See Margaret O'Brien, et al., "Integrating Children's Services to Promote Children's Welfare: Early Findings from the Implementation of Children's Trusts in England," *Child Abuse Review* 15 (2006): 377-395.

[8] *Child Wellbeing and Safety Act* 2005 (Vic) s.15(b). *The Department of Human Services* has recently conceded to the *Victorian Ombudsman* that the *Children's Services Co-ordination Board* should take a stronger lead in ensuring a whole-of-government approach to child protection. See Victorian Ombudsman, "Own Motion Investigation into the Department of Human Services Child Protection Program," *Victorian Ombudsman*, 2009, http://www.ombudsman.vic.gov.au/www/html/83-parliamentary-reports-2009.asp (1 April, 2011), 62 (¶324).

[9] See Jay Belsky, "Etiology of Child Maltreatment: A Developmental-Ecological Analysis," *Psychological Bulletin* 114 (1993): 413-434; Michael Lynch and Dante Cicchetti, "An Ecological-Transactional Analysis of Children and Contexts: The Longitudinal Interplay Among Child Maltreatment, Community Violence, and Children's Symptomatology," *Development and Psychopathology* 10 (1998): 235-257; and World Health Organization and International Society for Prevention of Child Abuse and Neglect, *Preventing Child Maltreatment: A Guide to Taking Action and Generating Evidence (*Geneva, Switzerland: WHO Press, World Health Organization; 2006), 13. [Hereinafter: WHO, *Preventing Child Maltreatment*]

[10] See World Health Organization, "Prevention of Child Abuse and Neglect: Making the Links between Human Rights and Public Health," *Child Rights Information Network*, 2001, http://www.crin.org/docs/resources/treaties/crc.28/who1.pdf (15 September, 2010). See also World Health Organization, "World Report on Violence," *World Health Organization*, 2002, http://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf (17 September, 2010), 4. [Hereinafter: WHO, *World Report on Violence*]

Furthermore, current public health models (e.g., Victoria's *Primary Care Partnerships*) suggest that adequately funded service integration and coordination will produce tangible benefits for children and their families by simplifying service system navigation; bolstering maltreatment prevention efforts; enhancing interagency information sharing so as to promote the early identification of risk; providing more sophisticated case planning and interagency case conferencing; and enabling knowledge transfer across the various fields involved in the support of children and families.[11]

First, when we ask what considerations are due to children, we must not restrict our concern to their mere protection from hurt and harm. As the *Council of Australian Governments* (COAG) has recognised in its *Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009–2020*:

> Australia needs to move from seeing 'protecting children' merely as a response to abuse and neglect to one of promoting the safety and wellbeing of children.[12]

Indeed, our notion of child protection should always include the positive and ultimate aim of ensuring that children are provided with an environment in which they may flourish, fully realising the capacities with which they are endowed as both persons and citizens.[13] This goal is explicitly recognised by

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[11] For information regarding PCPs, see the *Victorian Department of Health* website: http://www.health.vic.gov.au/pcps/evaluation/index.htm.

[12] Council of Australian Governments, "Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009-2020," *Council of Australian Gov ernments*, 2009, www.coag.gov.au/coag_meeting_outcomes/2009-04-30/docs/child_protection_framework.pdf (18 September, 2010), 7. [Hereinafter: COAG, "Protecting Children is Everyone's Business"]

[13] Ultimately, this goal remains vague so long as the capabilities that constitute the health and wellbeing of children remain largely unspecified. As such, *CPS* agrees with the findings of a recent report for the *Australian Research Alliance for Children and Youth* (*ARACY*) and the *Australian Institute of Health and Wellbeing* (*AIHW*). The report argues that a philosophical vision of 'the good life' is necessary if the needs of 'the whole child' are to be adequately addressed by policymakers. [See Australian Research Alliance for Children and Youth and the Australian Institute of Health and Welfare, "Conceptualisation of Social and Emotional Wellbeing for Children and Young People, and Policy Implications," *The Australian Research Alliance for Children and Youth*, 2010, http://www.aracy.org.au/cmsdocuments/SEWB%2007_071%20(2).pdf (12 September, 2010), ix & 6.] In line with the *ARACY* and *AIHW* report, *CPS* argues that Amartya Sen and Martha Nussbaum's *Capabilities Approach* to human development offers guidance regarding which capacities are central to realising children's potential and respecting their human dignity. For Nussbaum, a child's *central capacities* include: bodily health (e.g., nutrition, prompt and appropriate medical attention, etc.), attachments, emotional development (e.g., self-regulation), cognitive development (e.g., language and communication), education, play, as well as safety and protection from harm and exploitation. For a detailed description of these central capabilities, see *Appendix A*. See also Martha Nussbaum, *Frontiers of Justice: Disability, Nationality, Species Membership* (Cambridge: Harvard University Press, 2006), and Martha C. Nussbaum, *Creating Capabilities: The Human Development Approach* (Cambridge, Mass. & London: The Belknap Press of Harvard University Press, 2011).

both the United Nation's *Convention on the Rights of the Child 1989*[14] and Victoria's *Child Wellbeing and Safety Act 2005*:

> All children should be given the opportunity to reach their full potential and participate in society irrespective of their family circumstances and background.[15]

Children are essentially engaged in the task of development. Whether enjoying the pleasure of unstructured play or participating in highly organised learning activities, all of childhood's pursuits are aimed at preparing children for adulthood by developing their physiological, cognitive, emotional, social and cultural competencies. As such, the welfare of children involves not only their present state of health but also their capacity to realise the exigencies of development. *Ultimately, a child protection system can only succeed in its task of protecting children, when it is able to guard and foster the developmental processes that are at the heart of childhood.* These are complex processes involving multiple interactions between the child (i.e., her genes, temperament, behaviour, beliefs, etc.) and her physical environment (i.e., nutrition, toxins, pathogens, etc.) and social environment (i.e., caregivers, siblings, peers, day care centre, school, neighbourhood, society and culture). Moreover, these complex interactions are instrumental in the attainment of a myriad of different developmental outcomes (e.g., the acquisition of motor skills; achieving emotional regulation; undergoing cognitive development; mastering linguistic, social and cultural competencies; etc.).[16] Governments, through their considerable capacity for influencing the environments in which children mature, can and should seek to positively shape children's interactions with their environment and, thereby, interrupt adverse *gene-environment* interactions and promote positive developmental outcomes.[17]

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[14] "States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development." See United Nations, *Convention on the Rights of the Child 1989*, Article 27(1); see also Articles 27, 28, & 29.

[15] *Child Wellbeing and Safety Act* 2005 (Vic) s.5(1). Additionally, the *Children, Youth and Families Act 2005* (Vic) s.3 takes 'development' to mean: "physical, social, emotional, intellectual, cultural and spiritual development".

[16] J. P. Shonkoff and D. Phillips, *From Neurons to Neighborhoods: The Science of Early Child Development* (Washington: National Academy Press, 2000), 23f. [Hereinafter: Shonkoff and Phillips, *From Neurons to Neighborhoods*]

[17] UN, *Convention on the Rights of the Child 1989*, especially Articles 17, 19, 27-34. For the emerging importance of genetics and psychobiology in the science of child maltreatment intervention, see Michael J. Meaney, "Epigenetics and the Biological Definition of Gene x Environment Interactions," *Child Development* 81 (2010): 41-79, especially 69.

Given the complex nature of human maturation, any system that seeks to guard and foster healthy child development must adhere to an integrated, interdisciplinary, multi-modal and collaborative approach.[18] Only by adopting such an integrated approach can we hope to foster and maintain the environments necessary for ensuring that all Victorian children have the opportunity to grow up into healthy, resilient and productive members of society.[19]

Second, the conditions necessary for optimising child safety are ultimately the same conditions necessary for optimising their healthy development. Factors indicative of adverse developmental outcomes (e.g., low birth weight, lack of family resources, familial stress, having a young or inexperienced mother, parental substance abuse, adverse neighbourhood and community factors)[20] are also commonly associated with a heightened risk for child maltreatment.[21] Accordingly, the safety of children is maximised when children are able to mature within an environment conducive to their achieving the exigencies of human development (viz., physical health, emotional and cognitive maturity, resilience, and the realisation of their central capabilities). The indivisibility of child safety from the broader concerns of promoting healthy child development means that a maltreatment framework should not be constructed in isolation from the policy goals of fostering child health, resilience and wellbeing.[22] Consequently, CPS maintains that Victoria's child protection system must form part of a broad and integrated *Child Safety, Health and Wellbeing Strategy*.

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[18] See Shonkoff and Phillips, *From Neurons to Neighborhoods*, 399ff. See also WHO, *World Report on Violence*, 4. See also

[19] The need for an integrated approach to the protection of children in out-of-home care has recently been emphasised by the Victorian Ombudsman. See Victorian Ombudsman, "Own Motion Investigation into Child Protection – Out of Home Care," *Victorian Ombudsman*, 2010, http://www.ombudsman.vic.gov.au/www/html/280-parliamentary-reports-2010.asp (1 April, 2011), 45 (¶224).

[20] See for example, Shonkoff and Phillips, *From Neurons to Neighborhoods*, 5, 9, 267ff & 328ff.

[21] See *Appendix B*.

[22] See Michael S. Wald, "Preventing Maltreatment or Promoting Positive Development—Where Should a Community Focus its Resources?: A Policy Perspective," in *Preventing Child Maltreatment: Community Approaches*, ed. Kenneth A. Dodge and Doriane Lambelet Coleman (New York and London: The Guilford Press, 2009), 189.

RECOMMENDATION 1

Victoria's child protection system must form part of an integrated *Child Safety, Health and Wellbeing Strategy*. Such a strategy would address the needs of the 'whole child' by integrating the various aspects of children's lives (e.g. health, education, safety, civic participation, economic security, etc.) that have usually been treated separately by public policy.

A *Child Safety, Health and Wellbeing Strategy* should be organized according to the principle that each child is essentially engaged in the task of development and that it is responsibility of the whole Victorian community to create the physical and social environments necessary to foster healthy child development. Accordingly, a *Child Safety, Health and Wellbeing Strategy* will recognise that:

(a) A child protection system can only succeed in its task of protecting children when it is able to both guard and foster the developmental processes that are at the heart of childhood.

(b) Child development is a complex process involving multiple interactions between the child (i.e. her genes, temperament, behaviour, etc.) and her physical environment (i.e., nutrition, toxins, pathogens, etc.) and social environment (i.e., caregivers, siblings, peers, day care centre, school, neighbourhood, society and culture); and that these complex interactions are the necessary conditions for achieving various developmental outcomes (e.g., the acquisition of motor skills; achieving emotional regulation; undergoing cognitive development; mastering linguistic, social and cultural competencies; etc.). Accordingly, protecting children involves creating developmentally conducive environments in which children may achieve physical health, emotional and cognitive maturity, resilience, and the realisation of their central human capabilities.

(c) Creating developmentally conducive environments requires the integration and coordination of a wide range of policy initiatives, disciplines and intervention models, government departments and agencies, community support organisations, etc. As such, the child protection system should strive to work seamlessly with the providers of health services, education, law enforcement, etc.

(d) Children are the bearers of universal human rights and those human rights peculiar to childhood. In particular, a child's right to healthy development [*Child Wellbeing and Safety Act* 2005 (Vic) s.5(1)] should be scrupulously considered when drafting all legislation and when devising any policy initiative.

The purported synergy between children's safety and their health and wellbeing is borne out by the findings of the various sciences of child development (e.g., genetics, psychobiology, neuroscience, developmental psychology, etc.)[23] and the epidemiology of child maltreatment.[24] It is widely accepted that child development is an environmentally embedded process in which children, as protagonists in their own maturation, engage in increasingly complex transactions with their physical and social environment.[25] The social environment is made up of both immediate and mediated relationships (e.g., family, childcare centre, school, peers, neighbourhood, society, culture, etc.) whose developmental influence may be mapped according to their proximity to the child (see *Figure 1*). This view of child development is encapsulated within the so-called *ecological* or *bioecological* theory of human development.[26]

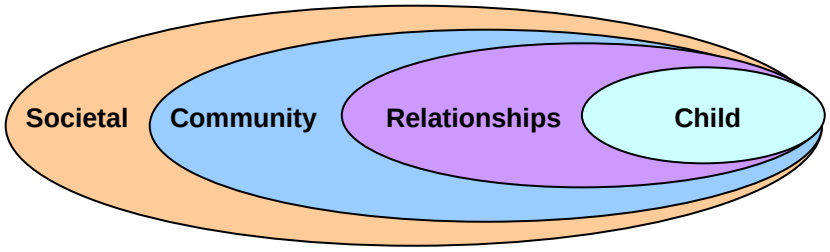

Figure 1 - Ecological model describing the risk factors for child maltreatment[27]

The multifactorial analysis of the bioecological approach has been profitably applied to the phenomenon of child maltreatment. Indeed, bioecological theory has become a central organising principle in the epidemiology of child abuse and neglect.[28] Current epidemiological research identifies the risk

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[23] See Shonkoff and Phillips, *From Neurons to Neighborhoods*.

[24] See for example, Fred Wulczyn, "Epidemiological Perspectives on Maltreatment Prevention," *The Future of Children* 19 (2009): 39-66.

[25] "The development of children is a highly complex process that is influenced by the interplay of nature and nurture. The influence of nurture consists of the multiple nested contexts in which children are reared, which include their home, extended family, child care settings, community, and society, each of which is embedded in the values, beliefs, and practices of a given culture. The influence of nature is deeply affected by these environments and, in turn, shapes how children respond to their experiences." See Shonkoff and Phillips, *From Neurons to Neighborhoods*, 23f.

[26] See Urie Bronfenbrenner, *The Ecology of Human Development: Experiments by Nature and Design* (Cambridge, MA: Harvard University Press, 1979); Urie Bronfenbrenner and Pamela A. Morris, "The Bioecological Model of Human Development," *Theoretical Models of Human Development.* vol. 1 of *Handbook of Child Psychology*, ed. Richard Lerner (New Jersey, John Wiley & Sons, Inc., 2006), 814ff;

[27] *Figure 1* is contrived from a model appearing in WHO, *Preventing Child Maltreatment*, 13.

[28] See Jay Belsky, "Etiology of Child Maltreatment: A Developmental-Ecological Analysis," *Psychological Bulletin* 114 (1993): 413-434; Michael Lynch and Dante Cicchetti, "An Ecological-Transactional Analysis of Children and Contexts: The Longitudinal Interplay Among Child Maltreatment, Community Violence, and Children's Symptomatology,"

factors and protective factors involved in the incidence of child maltreatment and plots them according to the ecological level at which they operate.[29] Researchers have found risk and protective factors operate at every level of a child's developmental environment. Moreover, these factors interact across ecological domains and in a bi-directionally causative fashion, exacerbating or mitigating risk according to the preponderance of risk versus protective factors.[30] Accordingly, research strongly indicates that population-wide child maltreatment prevention effects, along with sustainable post-maltreatment intervention results, can only be ensured when protective factors are promoted and risk factors minimised at every level of child's developmental environment.

Yet, despite the epidemiological evidence most child maltreatment prevention and treatment strategies limit their attention to the modification of caregiver behaviour. While research suggests that caregiver behaviour is malleable, nevertheless, it also indicates that changing caregiver behaviour is difficult and that many such efforts fail.[31] The inconsistent success of caregiver-orientated prevention and treatment programs is partly explicable in the light of the environmentally nested nature of child maltreatment. Interventions that simply work with caregiver behaviour and beliefs, risk leaving unaddressed important economic, neighbourhood, social and cultural risk factors associated with maltreatment. These risk factors continue to press upon a family's functioning long after caregiver-focused intervention programs have come to an end. These higher-level risk factors have the power to corrode the gains that any such family may have made during their participation in caregiver-focused intervention programs. This is especially true when there are few protective factors operating in the family's environment. Additionally, these higher-level risk factors continue to contribute to the generation of future 'at risk' families. Consequently, if we are to prevent child maltreatment, bolster early intervention and strengthen caregiver-orientated and child-focused treatment programs, then we must necessarily deploy universal and targeted interventions across the whole

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Development and Psychopathology 10 (1998): 235-257; Wulczyn, "Epidemiological Perspectives on Maltreatment Prevention", 39-66; Kenneth A. Dodge et al., "Community-Level Prevention of Child Maltreatment: The Durham Family Initiative," in *Preventing Child Maltreatment: Community Approaches*, ed. Kenneth A. Dodge and Doriane Lambelet Coleman (New York and London: The Guilford Press, 2009), 68-81.

[29] *Appendix B* provides a summary arranged according to ecological level of the risk factors and protective factors involved in child maltreatment, see below p.2f.

[30] Belsky, "Etiology of Child Maltreatment: A Developmental-Ecological Analysis", 420.

[31] Shonkoff and Phillips, *From Neurons to Neighborhoods*, 261.

development environment.[32] As such, when working with 'at risk' families, a comprehensive child protection strategy must take a *whole-of-family approach* and attend to issues like father-inclusive practice; caregiver stress and isolation; the provision of adequate and secure housing; the creation of employment opportunities; the eradication of neighbourhood violence; the over-accessibility of alcohol; the occurrence of racial discrimination; the presence of culturally permissive attitudes toward the mistreatment of children and women; as well as the usual targets of caregiver belief and behaviour.

RECOMMENDATION 2

A Victorian *Child Safety, Health and Wellbeing Strategy* must adopt a bioecological approach to child development and child maltreatment. Adopting a bioecological approach entails a commitment to promoting known protective factors and reducing known risk factors at every level of children's development environment. A *Child Safety, Health and Wellbeing Strategy* should be expressly organised according to this aim, mapping protective factors and risk factors to their relevant ecological level and then identifying the preventative, early intervention and treatment strategies associated with their promotion or reduction.

Such a whole-of-family approach honours the rights of caregivers and respects their decisively instrumental value for healthy child development.[33] However, such an approach is always bounded by the unassailable obligation that all parties should act in the *best interests of the child*. In most cases, the best interests of the child are superordinate over the interests of all other parties (including both the interests of caregivers and the state).[34] Usually, the best interests of the child entail supporting 'at risk' families to provide better

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[32] The *Triple P-Positive Parenting Program* (*Triple P*) is one current model that seeks to operate at every ecological level. Initially developed at the University of Queensland, *Triple P* is informed by social learning principles, a cognitive behaviour therapy approach, a population health approach and a socio-ecological approach to family intervention. It has also undergone considerable evaluation. See Matthew R. Sanders, Carol Markie-Dadds and Karen M.T. Turner, "Theoretical, Scientific and Clinical Foundations of the Triple P-Positive Parenting Program: A Population Approach to the Promotion of Parenting Competence," *Parenting Research and Practice Monograph* No.1. (St. Lucia, Queensland, Australia: The Parenting and Family Support Centre at the University of Queensland, 2003); and Ronald J. Prinz, "Toward a Population-Based Paradigm for Parenting Intervention," in *Preventing Child Maltreatment: Community Approaches*, ed. Kenneth A. Dodge and Doriane Lambelet Coleman (New York and London: The Guilford Press, 2009), 55-67.

[33] See UN, *Convention on the Rights of the Child 1989*, Preamble & Article 5; *Charter of Human Rights and Responsibilities Act 2006* (Vic) s.17.

[34] See UN, *Convention on the Rights of the Child 1989*, Article 3; and *Charter of Human Rights and Responsibilities Act 2006* (Vic) s.17(2); *Children, Youth and Families Act 2005* (Vic) s.10; and *Child Wellbeing and Safety Act* 2005 (Vic) s.5(1c).

care, while supplementing any deficiencies through child-focused supports (e.g., day care centres, school programs, etc.).[35] Nevertheless, in extreme cases the removal of a child from their family is in that child's best interests.[36] In such cases, out-of-home care must also be designed to maximise the protective factors and minimise risk factors at every level of the child's new developmental environment.[37]

In light of the above, CPS maintains that Victoria should adopt a *public health approach* to child maltreatment. Such an approach is in line with the *World Health Organisation*'s (*WHO*) guidelines on violence and child maltreatment.[38] A public health approach is characterised by an emphasis on prevention.[39] It is also marked by the type of integrated, interdisciplinary and multi-modal approach necessary for an effective *Child Safety, Health and Wellbeing Strategy*.[40] Historically, public health has had infectious disease as its main focus.[41] However, more recently health has come to be understood as more than the mere absence of disease:

> Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.[42]

Consequently, the field of public health has come to be concerned with the behavioural, psychological and socio-cultural factors involved in maintaining health.[43] These various factors are referred to as the *social determinants of*

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[35] See *Child Wellbeing and Safety Act* 2005 (Vic) s.5(1d).
[36] See UN, *Convention on the Rights of the Child 1989*, Article 9; and *Children, Youth and Families Act 2005* (Vic) s.10 (3g)
[37] See UN, *Convention on the Rights of the Child 1989*, Article 20.
[38] See World Health Organization, "Prevention of Child Abuse and Neglect: Making the Links between Human Rights and Public Health," *Child Rights Information Network*, 2001, http://www.crin.org/docs/resources/treaties/crc.28/who1.pdf (15 September, 2010). See also WHO, *World Report on Violence*, 4.
[39] WHO, *World Report on Violence*, 4.
[40] "Cooperative efforts from such diverse sectors as health, education, social services, justice and policy are necessary to solve what are usually assumed to be purely ''medical'' problems. Each sector has an important role to play in addressing the problem of violence and, collectively, the approaches taken by each have the potential to produce important reductions in violence." See WHO, *World Report on Violence*, 4.
[41] Amy M. Smith Slep and Richard E. Heyman, "Public Health Approaches to Family Maltreatment Prevention: Resetting Family Psychology's Sights from the Home to the Community," *Journal of Family Psychology* 22 (2008): 519. See also Ronald J. Prinz, "Toward a Population-Based Paradigm for Parenting Intervention," in *Preventing Child Maltreatment: Community Approaches*, ed. Kenneth A. Dodge and Doriane Lambelet Coleman (New York and London: The Guilford Press, 2009), 55-67.
[42] World Health Organization, "Constitution of the World Health Organization," *World Health Organization*, 2006, http://www.who.int/governance/eb/who_constitution_en.pdf (1 September, 2010), Preamble.
[43] Smith Slep and Heyman, "Public Health Approaches to Family Maltreatment Prevention: Resetting Family Psychology's Sights from the Home to the Community", 519.

health.[44] These social determinants of health are largely responsible for the health inequalities that characterise our communities. That is, where one segment of the population (e.g., Indigenous communities) enjoys a markedly poorer health status than that of other segments of the population (e.g., non-Indigenous communities), then this inequality is largely explicable in terms of these social determinants.[45] Clearly, many of these social determinants of health coincide with those factors identified as influencing the risk of child maltreatment (e.g., poverty and low income, caregiver stress, gender, disability, addiction, etc.).[46] A public health approach complements the bioecological approach in as much as they both recognise the need to tackle the risk of child maltreatment at every level of the child's developmental environment. Furthermore, by deploying a public health approach to child maltreatment one is in a position to exploit the considerable theoretical and practical knowledge that has already accrued in the fields of community health promotion and disease prevention.

RECOMMENDATION 3

A Victorian *Child Safety, Health and Wellbeing Strategy* should adopt an integrated public health approach to the promotion of child health and wellbeing, and for the prevention, early intervention and treatment of child abuse and neglect.

In sum, CPS argues that Victoria needs an integrated *Child Safety, Health and Wellbeing Strategy*, which will seek to foster developmentally friendly environments for all Victorian children. Ultimately, an environment is conducive to the safety, health and wellbeing of children when it is characterised by a preponderance of protective factors, the presence of few risk factors, a favourable constellation of the social determinants of health,[47] and an effective legal framework that enshrines and protects the human rights of children and their caregivers.[48] As such, a Victorian *Child Safety,*

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[44] See *Appendix C*.
[45] World Health Organization, "Social Determinants of Health," *World Health Organization*, 2011, http://www.who.int/social_determinants/en/ (10 January, 2011).
[46] Compare the list the social determinants of health (see *Appendix C*) with the list of child maltreatment risk factors (*Appendix B*).
[47] WHO, "Prevention of Child Abuse and Neglect: Making the Links between Human Rights and Public Health" 1ff; and World Health Organization, "Social Determinants of Health," 1ff.
[48] See Richard Reading et al., "Promotion of Children's Rights and Prevention of Child Maltreatment," *The Lancet* 373 (2009): 332-343. See also the relevant human rights instruments, especially but not limited to the "Declaration of the Rights of the Child 1959", *UNDemocracy*, 2010, http://www.undemocracy.com/A-RES-1386(XIV).pdf (8 September, 2010); the *Convention on the Rights of the Child 1989*, the various optional *Convention*

Health and Wellbeing Strategy must have as its central organising principle a commitment to promoting protective factors and retarding risk factors at every level of the development environment. The strategy should be expressly organised around this aim; it should map protective and risk factors to their relevant ecological level and then identify the preventative and treatment strategies associated with their promotion or reduction. This ecological approach must be allied with a public health approach that aims to positively influence the social determinants of health through integrated, evidence-based, interdisciplinary and multi-modal prevention, early intervention and treatment efforts.[49]

Protocols; the "Declaration on the Rights of Indigenous Peoples," (esp. Articles 7, 14, 21 & 22), *The United Nations*, 2007, http://www.un.org/esa/socdev/unpfii/en/drip.html (16 September, 2010); the *Australian Human Rights Commission Act 1986*, and the *Charter of Human Rights and Responsibilities Act* 2006 (Vic).

[49] Importantly, the *World Health Organisation* has used ecological theory to organise its public health approach to child maltreatment and to violence more generally. See WHO, *Preventing Child Maltreatment* 13, and WHO, *World Report on Violence* 12ff.

PREVENTION [1.1–1.1.5]

Creating local *Child Safety, Health and Wellbeing Partnerships*: We now turn to the first of the *Inquiry's* areas of specific interest; namely, the issue of preventing child maltreatment. As already stated, CPS believes that current research reveals that population-wide prevention effects can only be brought about through the deployment of a combination of universal and targeted interventions across every domain of the developmental environment.[50] As such, CPS recommends that the Victoria Government construct an integrated *Child Safety, Health and Wellbeing Strategy*, which aims to promote protective factors and minimise risk factors across every dimension of the child's developmental environment. However, if such a strategy is to be effective, then it must be incarnated at a local level.[51] In order to achieve better local planning, integrated and coordinated service delivery, and the fostering of developmentally friendly environments, CPS suggests that the Victorian Government create local *Child Safety, Health and Wellbeing Partnerships* (*CSHWPs*) to advance the goals of the herein proposed *Child Safety, Health and Wellbeing Strategy*.

RECOMMENDATION 4

Research indicates that the aetiology of child maltreatment is multifactorial, with protective factors and risk factors operating at every level of the child's developmental environment. Moreover, these factors interact across ecological domains. Such interactions can frustrate the hopes of single-factor intervention programs by either undermining their effectiveness or corroding their success over time. Accordingly, population-wide prevention effects can only be brought about through the deployment of a combination of universal and targeted interventions across every domain of the developmental environment. Consequently, a comprehensive Victorian *Child Safety, Health and Wellbeing Strategy* must provide an integrated prevention platform that comprises a suite of targeted and universal interventions for the promotion of known protective factors and the minimisation of known risk factors at every level of the child's developmental environment.

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[50] See above, p.2f.

[51] This conforms to the demands of s. 5(2b) of the *Child Wellbeing and Safety Act 2005* (Vic). It should be noted that here 'local' refers to both a geographically local area (e.g., Victorian Government Regions or Local Government Areas) and to culturally specific groups (e.g., Aboriginal).

As argued above, the *bioecological approach* and the *public health approach* both dictate that a comprehensive child maltreatment prevention strategy must be an interdisciplinary, multi-modal and collaborative strategy. As such, no single agency or government department can hope to provide all the interventions necessary to create comprehensive, sustainable and population-wide child maltreatment prevention effects. Rather, in keeping with US models such as the *Durham Family Initiative*[52] and the *Stronger Communities for Children* program,[53] CPS maintains that a comprehensive child maltreatment prevention strategy necessarily involves the strategic partnership of multiple stakeholders (e.g., state and local government, community health services, women's health services, Aboriginal health services, Primary Care Partnerships, alcohol and other drug services, mental health services, maternal and child health nursing, other child and family specialist services, specialist therapeutic services for children (e.g., CAMHS), schools and day-care centres, General Practitioners, police, etc.). Accordingly, CPS advocates the creation of local *Child Safety, Health and Wellbeing Partnerships* (*CSHWPs*). These would be local strategic alliances for the prevention of child maltreatment and the promotion of child health and wellbeing. Each *CSHWP* would be tasked with local planning for the promotion of protective factors and the minimising of risk factors associated with maltreatment. Governed by an interagency Memorandum of Understanding, each *CSHWP* would adopt the principles of the *bioecological approach* and the *public health approach* to the prevention of child maltreatment. They would also have a service integration and coordination responsibility (e.g., information sharing, common assessment tools, referral pathways, etc.) through which they would seek to strengthen early intervention, improve interagency case conferencing and promote knowledge transfer across the relevant government and non-government bodies. Along

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[52] See Kenneth A. Dodge, et al., "The Durham Family Initiative: A Preventive System of Care," *The National Center for Biotechnology Information*, 2004, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2765104/pdf/nihms146213.pdf (8 February, 2011), 1-11; and Kenneth A. Dodge et al., "Community-Level Prevention of Child Maltreatment: The Durham Family Initiative", in *Preventing Child Maltreatment: Community Approaches*, ed. Kenneth A. Dodge and Doriane Lambelet Coleman (New York and London: The Guilford Press, 2009), 68-81.

[53] See Robin J. Kimbrough-Melton and Dottie Campbell, "Strong Communities for Children: A Community-wide Approach to Prevention of Child Abuse and Neglect," *Family and Community Health* 31 (2008): 100-112; Gary B. Melton, Bonnie J. Holaday and Robin J. Kimbrough-Melton, "Community Life, Public Health, and Children's Safety," *Family and Community Health* 31 (2008): 84-99; and Gary B. Melton, "How Strong Communities Restored My Faith in Humanity: Children Can Live in Safety," in *Preventing Child Maltreatment: Community Approaches*, ed. Kenneth A. Dodge and Doriane Lambelet Coleman (New York and London: The Guilford Press, 2009), 82-101.

with integrating and coordinating existing caregiver and child-focused prevention programs, each *CSHWP* would have the particular responsibility of marshalling interventions aimed at promoting the protective factors and reducing the risk factors operating at the ecological level of the local neighbourhood and community.

RECOMMENDATION 5

Creating population-wide prevention effects, through strategic interventions at every level of the child's developmental ecology, requires an integrated, interdisciplinary, multi-modal and collaborative approach. No single agency can hope to provide all the interventions needed to foster and maintain the developmentally-friendly environments necessary to ensure child safety, health and wellbeing. Therefore, CPS advocates the creation of local *Child Safety, Health and Wellbeing Partnerships* (*CSHWPs*). These would be local strategic alliances for the prevention of child maltreatment and the promotion of child health and wellbeing. Each *CSHWP* would advance the proposed Victorian *Child Safety, Health and Wellbeing Strategy* by local prevention planning, local health promotion, local service integration and coordination responsibilities (e.g., information sharing, common assessment tools, referral pathways, etc.), improved case-planning and inter-agency case conferencing protocols, and coordinating interventions aimed at promoting the protective factors and reducing the risk factors operating at the ecological level of the local neighbourhood and community. *CSHWP* membership would consist of specialist child and family services, specialist therapeutic services for children (e.g., CAMHS), state and local government, maternal and child health nursing, community health services, women's health services, Aboriginal health services, alcohol and other drug services, mental health services, local schools and day-care centres, local Division of General Practitioners, police, etc. Consideration should also be given to aligning *CSHWP* with their local *Primary Care Partnerships* (*PCPs*).

In Victoria, a similar model already exists within primary health. Initiated in 2000, *Primary Care Partnerships* (*PCP*s) usually incorporate two local government areas (*LGA*s) and focus upon the provision of primary health care. *PCP*s provide leadership in local service coordination, local service integration, and health promotion.[54] Their membership consists of Divisions of General Practice, local hospitals, Community Health Services, local government, District Nursing, specialist child and family services, women's health services, Aboriginal health services, housing services, mental health services, and alcohol and other drug services. All *PCP* partners are bound by a memorandum of understanding and they all agree upon a strategic plan

[54] For information regarding PCPs, see the *Victorian Department of Health* website: http://www.health.vic.gov.au/pcps/.

that targets particular local population health concerns. Accordingly, *PCP*s offer a model and possibly a vehicle for the development of *CSHWP*s. Additional models include the *Children's Trusts* established in the UK in the early 2000s,[55] as well as the already cited US-based *Durham Family Initiative* and the *Strong Communities for Children* program. The *CSHWP*s would aim to coordinate a comprehensive, multi-modal, interdisciplinary and multi-agency prevention effort. They would seek to embed the goals of child health and wellbeing into all relevant local government planning and policy; they would seek to coordinate and integrate current services; and they would seek to collectively advocate for the resources necessary to create local child friendly environments. Finally, like *PCP*s, each *CSHWP* would receive specific and additional funding for this new child maltreatment prevention work.

Evidence-Based Prevention Programs: In addition, to the construction of a Victorian *Child Safety, Health and Wellbeing Strategy* and its associated local *CSHWP*s, CPS believes that there are other measures that the Victorian Government should take to prevent child maltreatment. In particular, CPS notes the mounting evidence in favour of individual prevention programs like *Nurse-Family Partnerships* (*NFP*s)[56] and the *Triple P-Positive Parenting Program* (*Triple P*).[57] These two models constitute the most thoroughly evaluated and promising prevention programs currently in operation.[58] As a program targeted toward 'at risk' families, *NFP*s can be easily incorporated

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[55] O'Brien, et al., "Integrating Children's Services to Promote Children's Welfare: Early Findings from the Implementation of Children's Trusts in England", 377ff.

[56] David L. Olds, et al., "Long-term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect Fifteen-Year Follow-up of a Randomized Trial," *Journal of the American Medical Association* 278 (1997): 637-643; David Olds, et al., "Preventing Child Abuse and Neglect with Home Visiting by Nurses," in *Preventing Child Maltreatment: Community Approaches*, ed. Kenneth A. Dodge and Doriane Lambelet Coleman (New York and London: The Guilford Press, 2009), 29-54; and John Eckenrode, et al., "Long-term Effects of Prenatal and Infancy Nurse Home Visitation on the Life Course of Youths: 10-Year Follow-up of a Randomized Trial," *Archives of Pediatrics & Adolescent Medicine* 162 (2010): 9-42.

[57] Matthew R. Sanders, Carol Markie-Dadds and Karen M.T. Turner, "Theoretical, Scientific and Clinical Foundations of the Triple P-Positive Parenting Program: A Population Approach to the Promotion of Parenting Competence," *Parenting Research and Practice Monograph* No.1. (St. Lucia, Queensland, Australia: The Parenting and Family Support Centre at the University of Queensland, 2003); and Ronald J. Prinz, et al., "Population-Based Prevention of Child Maltreatment: The U.S. Triple P System Population Trial," *Prevention Science* 10 (2009): 1-12.

[58] See Adam M. Tomison, "Evaluating Child Abuse Prevention Programs," *Australian Institute of Family Studies*, 2000, http://www.aifs.gov.au/nch/pubs/issues/issues12/issues12.html (12 November, 2010), 4; and Richard P. Barth, "Preventing Child Abuse and Neglect with Parent Training: Evidence and Opportunities," *The Future of Children*, 2009, http://www.futureofchildren.org/futureofchildren/publications/journals/journal_details/index.xml?journalid=71 (10 November, 2010), 103.

into a *Child Safety, Health and Wellbeing Strategy* coordinated through local *CSHWP*s. CPS's own *Mentoring Mums*, *I'm a Dad* and *I'm an Aboriginal Dad* have much in common with the *NFP* model.[59] Furthermore, *Triple P* is specifically designed to influence each level of the developmental environment by using a combination of universal and targeted supports that seek to assist the most healthy and resilient families (universal supports) through to the most 'at risk' families (universal and targeted supports).[60] Additionally, the *Durham Family Initiative* and the *Stronger Communities for Children* programs show considerable promise in providing prevention interventions at the higher-levels of the child's developmental ecology.[61]

All these models, as well as CPS's own prevention programs (viz., *Mentoring Mums*, *I'm a Dad* and *I'm an Aboriginal Dad*), are informed by a *bioecological approach* to the prevention and treatment of child abuse and neglect.[62] Moreover, they would all be bolstered by a comprehensive state-wide *public health approach* to child maltreatment prevention. Finally, CPS suggests that influencing societal and cultural risk factors (e.g., social & cultural norms that promote or tolerate corporal punishment, violence, gender and racial discrimination and inequality, etc.) require State and Commonwealth action (e.g., laws, media campaigns, etc).[63]

RECOMMENDATION 6

Currently, *Nurse-Family Partnerships* and the *Triple P-Positive Parenting Program* are the prevention models with the most robust evidence base. However, the Inquiry should also attend to the emerging evidence for the efficacy of the *Durham Family Initiative* and the *Stronger Communities for Children* program. Finally, established public health models (e.g., Victoria's *Primary Care Partnerships*) should also be considered as instruments for the service integration and coordination that is needed to effectively prevent maltreatment and to promote children's health and wellbeing.

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[59] For more information about these programs, see the *Child Protection Society* website http://www.cps.org.au/.
[60] Sanders, Markie-Dadds and Turner, "Theoretical, Scientific and Clinical Foundations of the Triple P-Positive Parenting Program: A Population Approach to the Promotion of Parenting Competence", 1ff.
[61] See above, footnotes 52 & 53.
[62] See Olds, et al., "Preventing Child Abuse and Neglect with Home Visiting by Nurses", 33; and Sanders, Markie-Dadds and Turner, "Theoretical, Scientific and Clinical Foundations of the Triple P-Positive Parenting Program: A Population Approach to the Promotion of Parenting Competence", 4.
[63] See *Appendix B*.

Prevention and the Victoria's Aboriginal Community: As the *Inquiry* is also interested in which prevention strategies should be viewed as appropriate for Victoria's Aboriginal communities, it should be noted that CPS's *I'm and Aboriginal Dad* (*IAAD*) program, *NFP*s and the *Triple P* model have all been designed to work in an Indigenous context. The *IAAD* program is a support program for Aboriginal men whose partners attend the *Transitions Clinic* at *The Mercy Hospital for Women*. Relaunched on 4 May 2009, the program seeks to connect with prospective fathers in a way that makes the clinic a safer place for Aboriginal men. Through this *safety first* approach, the *IAAD* worker then seeks to draw these men into the antenatal care offered by the *Transitions Clinic*, while at the same time inviting them to become part of the *IAAD* men's community of mutual support and healing. From out of this community, the men may access the wide range of professional parental supports offered by CPS. Consequently, the *IAAD* program aims to support Aboriginal men in both their perinatal and postnatal roles. The program aims to support and strengthen the relationship Aboriginal men have with their partners and/or to foster and fortify the fathering these men give their children. The *IAAD* program seeks to achieve these ends by providing a culturally appropriate men's program. In 2009-2010, ninety-nine Aboriginal people made use of the IAAD perinatal and postnatal supports. However, the current demand for places exceeds supply and CPS is currently seeking to expand the *IAAD* program, while incorporating within it the results of the recent evaluations of the Indigenous *NFP* and *Triple P* models.

An *NFP* Indigenous model was recently piloted in South Australia, where it demonstrated success in offering support to ATSI families.[64] A similar approach has been successfully implemented by the *NSW Aboriginal Maternal and Infant Health Strategy* (AMIHS).[65] Likewise, the Australian Government has set up the ATSI focused *Australian Nurse-Family Partnership Program* across four sites, including one administered by the *Victorian Aboriginal Health Service* in Melbourne.[66] A version of the *Triple P*

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[64] Leda Sivak, Fiona Arney and Kerry Lewig, "A Pilot Exploration of a Family Home Visiting Program for Families of Aboriginal and Torres Strait Islander Children - Report and Recommendations: Perspectives of Parents of Aboriginal Children and Organisational Considerations," *University of South Australia*, 2008, http://www.unisa.edu.au/childprotection/documents/FHV.pdf (25 January, 2011).

[65] NSW Health, *NSW Aboriginal Maternal and Infant Health Strategy: Evaluation*, NSW Health, 2006, http://www.health.nsw.gov.au/pubs/2006/evaluation_maternal.html (24 January, 2011).

[66] As of 24 January, 2011, the *Australian Nurse-Family Partnership Program's* website http://www.anfpp.com.au/. See also the US *Nurse-Family Partnership* website http://www.nursefamilypartnership.org/.

model has also been culturally tailored for Indigenous Australians and recently implemented in southeast Queensland.[67] In the Queensland trial, group sessions were co-facilitated by a Child Health Nurse and an Indigenous Health Worker.[68] Evaluation of the Queensland *Triple P* trial indicates that the program succeeded in reducing the rate of reported child behavior problems and the use of dysfunctional parenting practices. These gains were still in place six months after the program had been completed. The program recorded high rates of consumer satisfaction and cultural acceptability.[69] This ATSI tailored *Triple P* model has since been trialed nationally. It has been implemented across 12 urban, rural and remote sites. The national trial has largely replicated the results of the Queensland trial.[70]

RECOMMENDATION 7

CPS draws the Inquiry's attention to those versions of *Nurse-Family Partnerships* and the *Triple P-Positive Parenting Program* that have been specifically modified to meet the needs of Aboriginal communities. Recent research indicates the efficacy of these programs. Additionally, the Inquiry should give consideration to the expansion of CPS's *I'm an Aboriginal Dad* program.

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[67] Karen M.T. Turner, Mary Richards and Matthew R. Sanders, "Randomised Clinical Trial of a Group Parent Education Programme for Australian Indigenous Families," *Journal of Paediatrics and Child Health* 43 (2007): 244.

[68] Turner, Richards and Sanders, "Randomised Clinical Trial of a Group Parent Education Programme for Australian Indigenous Families", 245.

[69] Turner, Richards and Sanders, "Randomised Clinical Trial of a Group Parent Education Programme for Australian Indigenous Families", 250.

[70] Karen M.T. Turner, "Supporting Indigenous Health Professionals: Key Issues and Supports for the Adoption of Evidence–based Behavioural Family Intervention in Indigenous Communities." *The Australian Research Alliance for Children and Youth*, 2007, http://www.aracy.org.au/publicationDocuments/TOP_Supporting_Indigenous_Health_Professionals_Key_issues_and_supports_for_the_adoption_of_evidence_based_behavioural_family_intervention_in_Indigenous_communities_2007.pdf (15 January, 2011).

EARLY INTERVENTION [2.1–2.4]

Turning to the second of the *Inquiry*'s areas of interest, namely, early intervention. Victoria's obligation to protect the welfare of all its children is best fulfilled by promoting protective factors, by preventing the occurrence of risk factors and by intervening early where such risk factors exist. Accordingly, CPS supports increased investment into early intervention and is itself currently engaged in several early intervention initiatives. These include (i) *ChildFIRST North East*, (ii) the pilot of an early childhood care and education program tailored to the needs of at-risk children and based on the methodologies of the *Carolina Abecedarian Project* and *Highscope/Perry Pre-school Study* models,[71] (iii) delivering various case management and therapeutic family support services, and (iv) providing counselling and therapy for children with sexualised or sexually abusive behaviours.

Creating local *Child Safety, Health & Wellbeing Partnerships*: While a prevention strategy seeks to avert the risk of child maltreatment from ever arising, a strategy of early intervention aims to identify, as early as possible, those children who are at-risk of abuse and neglect. The presence of two or more familial risk factors (e.g., caregiver mental illness, caregiver substance abuse, family violence, social isolation, poverty, young or inexperienced mother, etc.),[72] especially when coupled with child risk factors (e.g., chronic illness or disability, difficult temperament, etc.) and neighbourhood risk factors (e.g., poverty, inadequate housing, violence, lack of local child care supports, etc.),[73] significantly increases a child's risk of maltreatment. Accordingly, a key aspect of effective early intervention is the successful early identification of risk. However, information regarding the existence of discrete risk factors is commonly held by different agencies, many of which are not specialist child and family welfare agencies. As such, the early identification of risk requires efficient information sharing amongst different government departments, government agencies and community support organisations (e.g., mental health services, alcohol and other drug services, primary health services, emergency services, child care centres and schools, etc.).[74] Furthermore, once one has successfully identified risk, the next step,

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[71] For information about these models see the relevant websites: http://www.fpg.unc.edu/~abc/ and http://www.highscope.org/content.asp?contentid=219.
[72] See *Appendix B*.
[73] See *Appendix B*.
[74] See Leah Bromfield and Prue Holzer, "A National Approach for Child Protection: Project Report," *NSW Community Services*, 2008, http://www.community.nsw.gov.au/docswr/_assets/main/documents/childprotection_report.pdf (1 April, 2011), 48.

which is to work with the at-risk families to reduce risk and treat existing harm, requires further interagency information exchange, interagency referral, and interagency case conferencing and coordinated service delivery.

Unfortunately, one of the challenges facing the child protection system is a lack of trust between different professionals and agencies, whether they are within the system or ancillary to it (e.g., mental health services, alcohol and other drug services, police, housing services, health services, etc.). This lack of trust is bred and maintained by poor communication, resource competition, increasing service demand, growing case complexity, and constant structural change. Nevertheless, in order to effectively identify and protect at-risk children, professionals must be willing to work together.[75] Consequently, CPS maintains that an early intervention policy is best conducted within a *public health approach* to child maltreatment. As argued above, a public health approach provides the integrated, interdisciplinary and multi-modal framework necessary for successful prevention and early intervention. Moreover, the above advocated *CSHWP*s provide the means of developing local interagency trust. They are also vehicles for creating the appropriate interagency governance arrangements; information exchange, referral, case conferencing and case planning protocols; common assessment tools; collocated multidisciplinary teams;[76] and the knowledge transfer, necessary to enable a successful early intervention strategy.

RECOMMENDATION 8

Effective interagency information sharing is a necessary condition for the early identification of risk, while early risk-identification is a necessary condition for effective early intervention. Moreover, at-risk families often exhibit a complex set of risk factors (e.g., family violence, mental health, substance abuse, housing insecurity, etc.), which call for a suite of early interventions from several different agencies. As such, delivering effective early intervention requires interagency collaboration and coordination, which in turn demands interagency trust and clear collaboration protocols. Consequently, the Inquiry should consider the merits of establishing *CSHWP*s (see *Recommendation 5*) as a means of developing the interagency trust; information exchange, referral, case planning and conferencing protocols; common assessment tools; and knowledge transfer, needed to enable an effective early intervention strategy.

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[75] Andrew Cooper, Rachael Hetherington and Ilan Katz, "The Risk Factor: Making the Child Protection System Work for Children," *Demos*, 2003, http://www.demos.co.uk/files/The_Risk_Factor.pdf?1253012631 (15 March, 2011), 38.

[76] For the value of multidisciplinary teams in building interagency trust and cooperation, see Cooper, Hetherington and Katz, "The Risk Factor: Making the Child Protection System Work for Children", 42.

Case Conferencing and Case Coordination: It has been CPS's experience that interagency case conferencing is too little used within the child protection field. This is especially true in cases where multiple services are involved with an at-risk family, several of which are not specialist child and family support agencies (e.g., mental health services, alcohol and other drug services, primary health services, offender treatment services, etc.). Better and more frequent interagency case conferencing is vital for a robust early intervention strategy.[77] CPS maintains that three initiatives would support an increase in interagency case conferencing. First, government should determine that any agency or organisation (e.g., mental health services, alcohol and other drug services, etc.) that works with an individual who has the care of children is under a duty to consider the best interest of the children involved. This should be the case even where the children are not clients of that agency. Should such an agency arrive at a reasonable belief that children are at risk, then that agency must be able to demonstrate what steps they have taken to ensure the best interests of that child (e.g., reporting, interagency referral and case-conferencing, changes to the client's case plan to include appropriate family supports, etc.). However, such a duty would fall short of a mandatory reporting obligation. Second, the establishment of local *CSHWP*s – which would be tasked with creating interagency referral, assessment and collaborative case planning protocols – will provide a vehicle for advancing a culture of interagency collaboration.

RECOMMENDATION 9

Government should determine that any agency or organisation (e.g., mental health services, alcohol and other drug services, etc.) working with an individual who has the care of children is under a duty to consider the best interest of the children involved. Accordingly, should such an agency arrive at a reasonable belief that children are at risk, then that agency must be able to demonstrate what steps they have taken to ensure the best interests of that child (e.g., reporting, interagency referral and case-conferencing, changes to the client's case plan to include appropriate family supports, etc.). However, such a duty would fall short of a mandatory reporting obligation.

Finally, in complex cases involving multiple agencies working with high-risk families, case conferencing is not enough to ensure good interagency

[77] Such collaborative practice is already part of Domestic Violence Victoria's *Code of Practice for Specialist Family Violence Services for Women and Children* (6.8). [Find at http://www.cyf.vic.gov.au/__data/assets/pdf_file/0014/380201/code-of-practice-domestic-violence-vic-2006.pdf]

communication, effective interagency case planning and successful early intervention.[78] Rather, such cases require that a case coordinator be appointed to advocate for the best interests of the child, oversee interagency collaboration and, if necessary, direct individual services to act or to desists from acting. CPS argues that the Victorian government must make case conferencing and case coordination mandatory once cases have reach a certain level of complexity. Furthermore, CPS argues that such case coordination should fall under the purview of the proposed *Office of the Children and Youth Advocate*. The *OCYA*, as conceived by the *Victorian Law Reform Commission*, is to be tasked with advocating for the best interest of children who are at the threshold of being formally reported to child protection.[79] As such, the *OCYA*, if properly resourced, would be well placed to provide case coordination. It would also have the requisite authority to direct services to act in ways consistent with the best interests of the child.

RECOMMENDATION 10

The Inquiry should consider the merits of:

(a) Making case conferencing and coordination mandatory for complex cases involving at-risk families that exhibit several risk factors and are in receipt of services from a number of different types of agencies; and

(b) Granting the recently proposed *Office of the Children and Youth Advocate* the powers and resources necessary to provide case coordination in such complex cases.

[78] See Adam M. Tomison, "Interagency Collaboration and Communication in Child Protection Cases: Some Findings from an Australian Case Tracking Study," *Australian Institute of Family Studies*, 1999, http://www.aifs.gov.au/institute/pubs/papers/tomison4.html (1 April, 2011).

[79] Victorian Law Reform Commission, "Protection Applications in the Children's Court: Final Report," *Victorian Law Reform Commission*, 2010, http://www.lawreform.vic.gov.au/wps/wcm/connect/justlib/Law+Reform/Home/Completed+Projects/Child+Protection/LAWREFORM+-+Protection+Applications+in+the+Childrens+Court+Final+Report (1 March, 2011), 367ff. [Hereinafter VLRC, *Protection Applications in the Children's Court: Final Report*]

FAMILY SERVICES, STATUTORY PROTECTION SERVICES & OUT-OF-HOME CARE [3.1–3.5]

The *Inquiry*'s third area of interest is the "quality, structure, role and functioning of: family services; statutory child protection services…and out-of-home care".[80] We shall address these in turn.

Family Services* [3.1–3.3.4]*:

CPS suggests that one of the weaknesses of the current child protection system is the way it regards the advice of non-mandated community-based family services. Current statutory child protection services, Victoria Police and courts do not tend to seek out the advice of such services. Moreover, even when such advice is proffered, it is often undervalued or disregarded. For instance, it has been the experience of some CPS staff that if a mandated service and a non-mandated service disagree in their assessment of a child's risk for maltreatment, then deference is often given to the mandated service's assessment. At times, this deference can become dangerously presumptive. For example, when responding to concerns raised by CPS staff, one statutory child protection worker maintained that because the relevant mandated services had not raised any concerns, then CPS's assessment could be properly discounted. The absurdity of this prejudice is obvious when one acknowledges the fact that non-mandated community-based family services are likely to (i) have more detailed knowledge about the functioning of individual at-risk families, and (ii) possess greater experience and expertise in assessing risk, than do mandated services (e.g., schools). Additionally, the advice of non-mandated community-based family services is insufficiently used in legal proceedings, particularly when it comes to dealing with children and young people exhibiting sexually abusive behaviours. We discuss this point more thoroughly below.[81]

RECOMMENDATION 11

The Inquiry should consider how the wider child protection system might better value and make better use of the expert advice of non-mandated community-based family services.

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[80] See *Protecting Victoria's Vulnerable Children Inquiry: Guide to Making Submissions*, 3. [Find at: http://www.childprotectioninquiry.vic.gov.au/submissions.html]

[81] See below, p.2f.

With regard to *ChildFIRST*, CPS argues that this service has performed well in its task of providing a centralised child maltreatment referral point. Nevertheless, CPS recognises that *ChildFIRST* has failed to deliver the looked for reduction in demand for statutory child protection services. However, CPS maintains that insufficient capacity within the family support system is the predominant cause behind this failure. It is because of the relative paucity of community resources that *ChildFIRST* has had to refer cases to statutory child protection services that could otherwise have been handled by the community sector. It should be noted that placing such unnecessary demands upon statutory child protection services has significant cost implications. It costs the Victorian Government more to have a case managed by statutory child protection services than it does to have it managed by family support services. Accordingly, CPS suggests that the Victorian Government review how many referrals to *ChildFIRST* could have been handled by family services and then increase community sector capacity accordingly. In addition, CPS draws the *Inquiry*'s attention to the insufficient number of short and medium-term respite places.

RECOMMENDATION 12

The Victorian Government needs to increase capacity within the community family support sector in order to provide more referral points for ChildFIRST and, thereby, reduce service demand upon the statutory child protection system.

Statutory Child Protection Services* [3.4–3.4.3]*:

Clarifying Key Practice Concepts: The work of statutory child protection services, along with the rest of the child protection system, is encumbered and undermined by the vagueness and ambiguity of several key features of child protection practice. These ambiguities centre on the following questions: (i) What, for the purposes of initiating child protection proceedings, constitutes sufficient evidence of emotional abuse, cumulative harm, and abuse through exposure to family violence; and (ii) What constitutes 'good enough' parenting?

First, there needs to be greater clarity as to what counts as evidence of emotional abuse and cumulative harm.[82] Both phenomena are recognised

[82] For a discussion of the definitional problems involved in emotional abuse, see Danielle A. Black, Amy M. Smith Slep and Richard E. Heyman, "Risk Factors for Child Psychological Abuse," *Aggression and Violent Behavior* 6 (2001): 189–201.

forms of maltreatment[83] and appear, as such, in the *Children, Youth and Families Act 2005* (Vic).[84] While CPS passionately supports the current legislation, nevertheless, it finds little evidence that cases of emotional abuse and cumulative harm are being independently pursued within the child protection system. In our experience, emotional abuse and cumulative harm claims are mounted only when associated with claims of other types of acute, high-impact harm (e.g., 'severe physical abuse + cumulative harm'). Consequently, we see little evidence that the categories of emotional abuse and cumulative harm are being used as the legislation intended, namely, as claims that independently and sufficiently warrant finding a child to be in need of protection.

Seemingly contradicting the above observation is the fact that emotional abuse is the form of maltreatment most often substantiated in child protection proceedings. However, this apparent contradiction dissolves when one understands that (i) many of the cases that are resolved as emotional abuse substantiations, were commenced as cases involving other types of acute, high-impact maltreatment (e.g., physical abuse or sexual abuse), and (ii) subsequent 'plea bargaining' aimed at securing caregiver consent to protection orders, often results in the Department dropping allegations of acute, high-impact maltreatment, thereby, only retaining the emotional abuse charges. This practice is itself highly problematic. It produces three unwelcomed results: (a) it distorts prevalence statistics, (b) it does not do justice to the infringement of the rights to the mistreated child, and (c) it impedes the Court's capacity to make appropriate court orders. For instance, in cases involving sexual abuse but in which the Department has dropped the sexual abuse allegations and retained only the associated emotional abuse charges, the Court cannot make an order in which the perpetrator must undergo sex offender treatment. In such cases, the Court can only make orders consistent with the substantiation of the emotional abuse charge. This leaves the sexually abused child without the appropriate court ordered protections.

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[83] See WHO, "Child Maltreatment," *World Health Organization*, 2010; Price-Robertson and Bromfield, "What is Child Abuse and Neglect?", 4; & Leah M. Bromfield, Philip Gillingham and Daryl J. Higgins, "Cumulative Harm and Chronic Child Maltreatment," *Developing Practice* 19 (2007): 34-42.

[84] *Children, Youth and Families Act 2005* (Vic) ss.10(3e), 162(1e) & 162(2).

The lack of such proceedings initiated solely on the ground of emotional abuse or cumulative harm cannot be explained in terms of prevalence because the prevalence of emotional abuse (11%) is similar to that of neglect (12%) and higher than most estimates of physical abuse (5-10%).[85] Indeed, given that most mistreated children suffer multiple incidents of maltreatment and endure overlapping maltreatment types, it is reasonable to conclude that most mistreated children are at risk of suffering cumulative harm and emotional abuse.[86] CPS suggests that one of the reasons that child protection proceedings are not initiated on the grounds of emotional abuse and cumulative harm is because the child protection system remains event and crisis focused. Such an orientation leads to overlooking children who have not suffered 'significant' harm in any one episode of maltreatment but suffer the corrosive effects of constant low-level insults to their dignity, health and wellbeing.[87] Additionally, CPS believes that few independent emotional abuse and cumulative harm proceedings are initiated because there is little guidance from legislative, judicial, and policy sources as to what constitutes sufficient evidence for sustaining such allegations. Greater guidance would assist practitioners in successfully prosecuting cases of emotional abuse and cumulative harm. However, the courts and statutory child protection services must be receptive to such cases if the public, mandated services and family service practitioners are to be expected to initiate such proceedings. Finally, there is significantly less research available about the nature, harm and prevalence of emotional abuse.[88] The *Inquiry* should consider recommending that the Secretary support further research into this type of abuse.[89]

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[85] Rhys Price-Robertson, Leah Bromfield and Suzanne Vassallo, "The Prevalence of Child Abuse and Neglect," *Australian Institute of Family Studies*, 2010, http://www.aifs.gov.au/nch/pubs/sheets/rs21/rs21.pdf (15 September, 2010).

[86] See L. M. Bromfield and D.J. Higgins, "Chronic and Isolated Maltreatment in a Child Protection Sample," *Australian Institute of Family Studies*, 2005, http://www.aifs.gov.au/institute/pubs/fm2005/fm70/lb.pdf (6 November, 2010), 44; and Daryl J. Higgins and Marita P. McCabe, "Multi-Type Maltreatment and the Long-Term Adjustment of Adults," *Child Abuse Review* 9 (2000): 7.

[87] Robyn Miller, *Cumulative Harm: A Conceptual Overview* (Melbourne: Department of Human Services, 2007), 35.

[88] Nick Richardson and Leah Bromfield, "Who Abuses Children?," Resource Sheet No. 7, *Australian Institute of Family Studies*, 2005, http://www.aifs.gov.au/nch/pubs/sheets/rs7/rs7.pdf (October 1, 2010), 3; and Black, Smith Slep and Heyman, "Risk Factors for Child Psychological Abuse", 1ff.

[89] For the Secretary's role in encouraging child maltreatment research, see *Children, Youth and Families Act 2005* (Vic) s.16(1i).

Recommendation 13

The Secretary of the Department of Human Services should support further research into this type of abuse.

Although not explicitly identified as such in the *Children, Youth and Families Act 2005* (Vic), *witnessing family violence* is also a recognised form of child maltreatment.[90] Like emotional abuse and cumulative harm, CPS maintains that there is insufficient guidance from legislative, judicial, and policy sources as to when family violence should be considered a child protection matter and what constitutes sufficient evidence for initiating such proceedings. Consequently, CPS suggests that the Children's Court and the Victorian Government consider providing statutory child protection services, mandated services and community support organisations with greater guidance on this matter.

RECOMMENDATION 14

Despite the fact that emotional abuse, cumulative harm and maltreatment through witnessing family violence each constitute in themselves a reason for extending protections to children, there is little evidence that such cases are being independently pursued within the child protection system. Such claims seem to be made only when associated with claims of other types of acute harm (e.g., sexual abuse and physical abuse). Accordingly, there needs to greater guidance from legislature, judiciary, and the Department regarding (i) the conditions under which emotional abuse or cumulative harm or maltreatment through witnessing family violence - absent any other form of maltreatment – should trigger child protection proceedings; and (ii) what constitutes sufficient evidence for sustaining allegations of emotional abuse, cumulative harm, and maltreatment through witnessing family violence.

The second key practice notion that is encumbered by conceptual vagueness is what statutory child protection services consider to be 'good enough' parenting. Currently, community-based family services and statutory child protection services do not have a clear, agreed upon definition of what constitutes minimally adequate parenting. While some forms of maltreatment are clearly defined, nevertheless, there is no clearly defined threshold at which a family's functioning may be considered to have become so poor that it warrants interventions. Indeed, family services and statutory child protection

[90] Price-Robertson and Bromfield, "What is Child Abuse and Neglect?", 4.

services are often in disagreement about what constitutes such a threshold. A shared definition, abstracted from the service system demand pressures and framed in terms of the exigencies of child development, would greatly enhance the working relationship between family services and statutory child protection services.

Making Findings for all Allegations of Child Maltreatment: Turning to the question of current statutory child protection procedures, CPS has concerns about some aspects of current practice. Through its work with sexually abused children, CPS has observed that the Department fails to make a finding in many cases of alleged sexual abuse. This failure to make a finding usually occurs in a context in which the non-accused caregiver has given certain undertakings that amount to either (i) denying the alleged perpetrator any access to the allegedly abused child, or (ii) providing the alleged perpetrator with only supervised access to the allegedly abused child. Satisfied with these arrangements, the Department then withdraws from the case. For the sake of brevity, we shall call such cases 'protective parent cases'. CPS believes that this process of dealing with 'protective parent cases' fails to fulfil the Department's duty of care toward the alleged victim of abuse. Rather, the Department or Victoria Police should come to a finding in all serious allegations of child maltreatment. Furthermore, if the Department substantiates the allegations in a 'protective parent case', then it must engage the 'protective parent' in a rigorous planning process for the future safety of the mistreated child. The result of this process will be a *safety plan,* which has the agreement of both the Department and the 'protective parent'. Each *safety plan* should stipulate the timing of at least two departmental *safety plan reviews* (e.g., in 6 weeks and then again in 6 months), which will investigate whether the safety plan has been honoured and assess the wellbeing of the child who is the subject to the *safety plan*.

The reasons for having *safety plans* and *safety plan reviews* - even in 'protective parent cases' - is that at-risk families are often subject to radically changing circumstances. Moreover, 'protective parents' are often subject to violence and intimidation at the hands of the alleged perpetrator of child maltreatment.[91] Consequently, they may make certain good faith undertakings

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[91] Australian and international research estimate the overlap between intimate partner violence and child maltreatment is between 30-60%. See Adam M. Tomison, "Exploring Family Violence: Links between Child Maltreatment and Domestic Violence," *Australian Institute of Family Studies*, 2000, http://www.aifs.gov.au/nch/pubs/issues/issues13/issues13.html (1 November, 2010); and Department of Human Services, *The State of Victoria's Children*

to the Department and yet find themselves unable to fulfil these undertakings on account of subsequent acts of violence or intimidation by the alleged perpetrator. Alternatively, some self-purported 'protective parents' may have previously failed to prioritise child safety above their own interests. In such cases, the Department cannot simply rely upon the vague undertakings of these 'protective parents'. Knowing this, it is unconscionable for the Department to merely take the word of the 'protective parent' and then simply wait for any future acts of maltreatment to be reported. The Department's duty of care requires that it be more pro-active and prevention focused than current procedure stipulates.

Furthermore, if the Department is required to make a finding regarding all serious allegations of child maltreatment, then any future child protection matters that relate to that child (e.g., Children's Court proceedings, statutory child protection interventions, etc.) will be assisted by a record of previously substantiated abuse. Indeed, such a record seems to be of fundamental importance to any assessment of allegations of cumulative harm. A past claim of abuse that went without investigation and, therefore, remained unsubstantiated can do little to bolster a future case for intervention on the grounds of cumulative harm.

Accordingly, CPS suggests that the *Inquiry* consider the merits of the following process.[92] When an allegation of child maltreatment is made, then the Department and Victoria Police determine which body is appropriate to carry out the requisite investigation. If it is determined that Victoria Police should have carriage of the investigation, then Victoria Police will undertake to inform the Department of its findings. Having been informed by Victoria Police, the Department will then assess whether the findings of Victoria Police amount to a substantiation of the allegations on the balance of probabilities. (Obviously, given their differing evidentiary standards, it is possible that a police investigation will result in departmental substantiation but no criminal proceedings.) Irrespective of which body has carriage of the investigation, the Department is obliged to record a finding for all serious allegations of child maltreatment. For all cases (including 'protective parent cases') in which a substantiation finding is made, a *safety plan* must be

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Report 2006: Every Child Every Chance (Melbourne: Department of Human Services, 2006), 89 [Find at http://www.eduweb.vic.gov.au/edulibrary/public/govrel/Policy/children/sovcreport06.pdf].

[92] CPS acknowledges that some aspects of the described process are already part of standard statutory child protection's procedure.

constructed and then reviewed at least twice throughout the following 12 months.

RECOMMENDATION 15

The Department should be required to make a finding in all serious allegations of child maltreatment. Accordingly, the *Inquiry* should consider the merits of the following process. When an allegation of child maltreatment is made, then the Department and Victoria Police determine which body is appropriate to carry out the requisite investigation. If it is determined that Victoria Police should have carriage of the investigation, then Victoria Police will undertake to inform the Department of its findings. Having been informed by Victoria Police, the Department will then assess whether the findings of Victoria Police amount to a substantiation of the allegations on the balance of probabilities. Irrespective of which body has carriage of the investigation, the Department is obliged to record a finding for all serious allegations of child maltreatment. Finally, in all substantiated cases (including 'protective parent cases'), the Department must (at a minimum) devise a *safety plan* and then review this plan at least twice throughout the following 12 months.

Statutory Child Protection Workforce Issues: Finally, CPS wishes to comment on the long-standing workforce issues that have plagued Victoria's statutory child protection services.[93] These issues go to staff recruitment, staff retention, professional development and staff morale. The general community seems to have had an enduring crisis of confidence when it comes to statutory child protection services. This negative perception has been recently exacerbated by a series of highly critical Victorian Ombudsman reports.[94] Statutory child protection workers must feel as though they are under perpetual review, continually judged to be failing in their protective duties and constantly blamed for adverse child outcomes. Obviously, such a state of affairs is corrosive to staff morale and makes staff recruitment and retention difficult. Furthermore, "excessive workloads, poor management, poor career prospects and a lack of professional development opportunities" contribute to a very serious set of workforce challenges.[95] Difficulties in recruiting and retaining quality staff only serves to exacerbate workplace stress, disproportionate workloads and knowledge gaps, thereby, setting up

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[93] Victorian Ombudsman, "Own Motion Investigation into the Department of Human Services Child Protection Program", 104ff (¶¶545-575).

[94] See *Own Motion Investigation into the Department of Human Services Child Protection Program* (2009) and *Own Motion Investigation into Child Protection - Out of Home Care* (2010). [Find at http://www.ombudsman.vic.gov.au/www/html/285-parliamentary-reports-2011.asp]

[95] Victorian Ombudsman, "Own Motion Investigation into the Department of Human Services Child Protection Program", 105, (¶550).

the conditions for a cascading and self-perpetuating workforce crisis. Ultimately, these workforce issues endanger both the welfare of child protection staff and the safety of Victoria's vulnerable children.

CPS maintains that the statutory child protective system urgently needs a comprehensive workforce strategy. Such a strategy must endeavour to create sustainable cultural change within statutory child protective services. Accordingly, the statutory child protective system needs more than a simple short-term recruitment drive. Without addressing the underlying causes of workforce dissatisfaction, a short-term increase in staff numbers is unlikely to be sustainable as newly recruited staff will eventually come to be subjected to the same adverse workforce factors previously described.

CPS suggests that a comprehensive workforce strategy for statutory child protection services should speak to the following four areas. First, CPS suggests that the current role of the child protection worker needs to be fundamentally altered. Currently, child protection workers have the impossibly dual role of supporting at-risk families and policing them. These two roles are inherently at odds. CPS suggests that the roles need to be separated and the investigative and procedural elements handled by an independent statutory agency. We discuss the need for this separation below.[96]

Second, CPS believes that the adoption of a public health approach to child maltreatment could extend to applying a patient safety systems approach to client safety and the management of system error.[97] Such an approach moves away from a culture of individual blame to an analysis of the human, treatment and systemic factors that provide the multifactorial basis of most of the errors that occur within complex systems. The child protection system should aspire to be a 'high reliability' system like medicine and air traffic control.[98] Within high reliability systems, there is an acceptance that mistakes will be made and so considerable effort is put into training and supporting staff to recognise and recover from such mistakes. A systems approach to client safety is intended to have the effect of decreasing adverse client outcomes, while at the same time empowering and supporting staff. Such

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[96] See below, p.2ff.
[97] See Philippe Michel, "Strengths and Weaknesses of Available Methods for Assessing the Nature and Scale of Harm Caused by the Health System: Literature Review," *World Health Organisation*, 2011, http://www.who.int/patientsafety/research/P_Michel_Report_Final_version.pdf (4 April, 2011); and James Reason, "Human Error: Models and Management," *British Medical Journal* 320 (2000): 768-770.
[98] Reason, "Human Error: Models and Management", 770

staff support must be at the heart of any reform to the work culture of statutory child protective services.

Third, in keeping with the aforementioned systems approach, CPS argues that quality supervision and professional development are fundamental to creating effective work practices and resilient staff.[99] Quality supervision consists in a package of (i) effective oversight and support of staff by line managers and (ii) non-managerial professional supervision.[100] The confidentiality and expertise provided in professional supervision allows a practitioner to concentrate on improving their case management craft and maintaining their professional equilibrium within the potentially toxic environment of child protection.

The importance of supervision and professional development strongly argues against the current practice of assigning all unallocated cases to team leaders. Team leaders are tasked with the day-to-day supervision and support of staff. However, their current workloads, along with the spirit of crisis within which they work, undermine their capacity to adequately support staff and review case management. Accordingly, CPS argues that (a) all front-line statutory child protection workers receive regular formal professional supervision, and (b) the current practice of assigning all unallocated cases to team leaders should be suspended and team leaders should be supported and trained to provide appropriate staff support, coordination and professional oversight.

Fourth, a comprehensive statutory child protection services workforce strategy must aim at winning back public trust and confidence in the child protection system, along with instilling within statutory child protection workers a sense of authority. Here 'authority' means:

> The ability of the relevant professionals to work with confidence in their own knowledge and understanding, and confidence in the support of both their management and the wider community for their values. Without the flexibility and confidence of this kind of authority, interventions are tentative, bureaucratic and proceduralised.[101]

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[99] See Robyn Miller, "Best Interests Principles: A Conceptual Overview," *Department of Human Services*, 2006, http://www.cyf.vic.gov.au/every-child-every-chance/library/publications/best-interest-series/best_interests (15 March, 2011), 37ff; and Hetherington and Katz, "The Risk Factor: Making the Child Protection System Work for Children", 53.

[100] Miller, "Best Interests Principles: A Conceptual Overview", 37; and Hetherington and Katz, "The Risk Factor: Making the Child Protection System Work for Children", 53.

[101] Cooper, Hetherington and Katz, "The Risk Factor: Making the Child Protection System Work for Children", 14.

Staff morale will grow as their efforts become trusted and valued by the community for which they work. Staff self-confidence will grow in proportion to the sense of authority they achieve in relation to their work.

RECOMMENDATION 16

The Department must devise a comprehensive workforce strategy for the statutory child protective system. This strategy should involve:

(a) Creating a long term recruitment and retention strategy;

(b) Recognising that current child protection workers have the impossibly dual role of supporting at-risk families and policing them. These two roles are inherently at odds and should be separated. Departmental child protection workers should concentrate on family support, while the investigative and procedural responsibilities should be handled by an independent statutory agency;

(c) Applying a patient safety systems approach to client safety and the management of system error;

(d) Providing all statutory child protection workers with regular non-managerial professional supervision;

(e) Ending the practice of awarding all non-allocated cases to team leaders and supporting team leaders to provide appropriate staff support, coordination and professional oversight; and

(f) Winning back public trust and confidence in the child protection system, along with instilling within statutory child protection workers a sense of confidence and authority.

Out-of-Home Care* [3.5–3.5.7]*:

Victorian Ombudsman's Report: With regard to out-of-home care, CPS endorses the recommendations of the recent Victorian Ombudsman's Report.[102] In particular, CPS wishes to endorse the one recommendation (viz., Recommendation 8) that the Department has so far declined to take up.[103] CPS agrees with the Victorian Ombudsman that the Department has a potential conflict of interest when it comes to the registration and regulation of community service organisations (CSOs).[104] Departmental reliance upon its

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[102] Victorian Ombudsman, "Own Motion Investigation into Child Protection – Out of Home Care", 1ff.

[103] *Recommendation 8* reads: "Transfer the function of registering community service organisations to an independent Office which has no reliance on the services being provided by the agency being registered." See Victorian Ombudsman, "Own Motion Investigation into Child Protection – Out of Home Care", 58.

[104] Victorian Ombudsman, "Own Motion Investigation into Child Protection – Out of Home Care", 57.

funded agencies can become so significant that it influences decision making about competency and performance. Furthermore, if a CSO were to be found to have provided an inadequate standard of care to children in out-of-home care, then such a judgement may amount to a failure by the Department to meet its statutory obligations.[105] Concomitantly, the relevant employees of the Department could be perceived to have an interest in avoiding the appearance of Departmental failure. Such an interest conflicts with the Department's obligations as a regulator. While CPS accepts this reasoning and the Ombudsman's recommendation, CPS also maintains that the Department suffers additional conflicts amongst its various responsibilities. We shall address this issue below.[106]

RECOMMENDATION 17

CPS endorses the recommendations of the Victorian Ombudsman's *Own Motion Investigation into Child Protection – Out of Home Care*. In particular, CPS endorses *Recommendation 8*, which the Department has so far declined to implement.

Improving Placement Planning: CPS suggests that the current system for out-of-home care suffers from a structural problem regarding the placement of young people into residential care. Young people tend to enter into residential care in a situation of crisis; their need for the protection and support of residential care usually presents as both immediate and overwhelming. Such urgency tends to work against careful planning in residential placement process. The result is that too many young people are placed into living situations that are inappropriate in light of their specific needs. Such inappropriate placements are a significant contributing factor to the high level of instability amongst residential placements. This instability works against the interests of at-risk young people who require environmental stability and the opportunity to cement long-term positive attachments to support staff.

As such, the residential support system is faced with two permanent and competing demands. On the one hand, the system must be able to respond to the urgent placement needs of at-risk young people. On the other hand, it is in the best interests of young people that residential placements are made after careful planning. While these two competing demands cannot be

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[105] Victorian Ombudsman, "Own Motion Investigation into Child Protection – Out of Home Care", 57 (¶303).
[106] See below, p.2ff.

avoided, CPS believes that they can be managed. Accordingly, CPS suggests that the Victorian Government consider the merits of developing short-stay residential crisis units in which young people may be initially placed pending placement in long-stay residential units. During their initial placement within a short-stay residential crisis unit, residential support staff would be responsible for the careful planning needed for ensuring that the young person's long-stay placement is conducive to their recovery and future development.

RECOMMENDATION 18

The Inquiry should consider the merits of developing short-stay residential crisis units in which young people in urgent need of out-of-home care may be initially placed pending their placement in long-stay residential units. During their initial placement, residential support staff would carefully plan each young person's long-stay placement. Long-stay placement options should be selected according to the specific needs of each young person, aiming to provide the best available environment for fostering recovery and promoting future development.

In regards to improving outcomes for those in out-of-home care and those leaving such care, CPS endorses the recently released *National Standards for Out-of-Home Care* and encourages the Victorian Government to comply with these standards.[107] In particular, the *National Standards for Out-of-Home Care* makes it clear that children's views should inform all decisions about their care.[108] CPS fully endorses this principle and suggests that the *Office of the Children and Youth Advocate* (*OCYA*), recently recommended by the *Victorian Law Reform Commission*, would be well placed to ensure adherence to this principle. Obviously, day-to-day decisions regarding the care of children within the child protection system should be made by caregivers and child protection staff working together in the best interests of the child. Formulation of these interests must take in account the views of the child themselves and these views should be weighted according to their merit and the maturity of the child. However, CPS suggests that there are certain key decisions (e.g., residential placement) for which children should have

[107] Department of Families, Housing, Community Services and Indigenous Affairs, "An Outline of National Standards for Out-of-Home Care," *Department of Families, Housing, Community Services and Indigenous Affairs*, 2010, http://www.fahcsia.gov.au/sa/families/pubs/nat_std_4_outofhomecare/Documents/PAC_national_standard.pdf (1 April, 2011). [Hereinafter FaHCSIA, *An Outline of National Standards for Out-of-Home Care*]

[108] This is articulated in *Standard 2* of the *National Standards for Out-of-Home Care*. See FaHCSIA, *An Outline of National Standards for Out-of-Home Care*, 8.

access to the advice and representation of an independent advocate. Such key decisions are characterised by (i) having a significant impact upon a child's life and (ii) having the potential to improperly curtail respect for the child's human rights. The proposed *OCYA* is already envisaged to have an independent advocacy role during child protection proceedings; it would not be very difficult to extend this role to other key points of decision-making. Furthermore, the *Inquiry* might consider whether the vulnerability of young people in residential care is so significant as to warrant the appointment of an *OCYA* advocate to all young people in residential care. Under such arrangements, every young person in residential care could seek advice from their appointed advocate at any stage during their residential placement.

RECOMMENDATION 19

CPS endorses the recently released *National Standards for Out-of-Home Care* and encourages the Victorian Government to comply with these standards.

RECOMMENDATION 20

The Inquiry should consider the merits of having the proposed *Office of the Children and Youth Advocate* appoint a permanent advocate for every child and young person in residential care.

Supporting Children Exhibiting Sexually Abusive Behaviours: CPS is particularly concerned about the treatment of children exhibiting sexually abusive behaviours (SAB).[109] During the course of treating and supporting this cohort of children, CPS staff have encountered a tendency within the child protection system to preclude these children from accessing foster care. While there are a number of legitimate concerns regarding the placement of these children in foster homes (e.g., the safety of other children in the foster home), none of these concerns is unmanageable. For instance, children who have exhibited SAB could be precluded from those foster homes in which there are vulnerable persons. Furthermore, child protection could pursue a dedicated strategy of recruitment, training and on-going support for carers willing to foster this cohort of young people. Indeed, such a policy should be viewed as part of a comprehensive child maltreatment prevention and early

[109] Cameron Boyd, "Young People who Sexually Abuse: Key Issues," Australian Institute of Family Studies, 2006, http://www.aifs.gov.au/nch/pubs/brief/pb1/pb1.pdf (1 April, 2011).

intervention strategy. Children who have exhibited SAB continue to enjoy the same right to healthy development as that enjoyed by all other children. As such, restricting their access to foster care, or any other form of child and family support, can only be condoned when there is clear evidence that access would place others at risk. In such cases of legitimate restriction, our duty of care to this cohort of young people requires us to find alternative means of providing them with the same or very similar services.

RECOMMENDATION 21

The Inquiry should consider whether or not children who have exhibited sexually abusive behaviour are being unreasonably denied access to foster care. If such discrimination is occurring, then the Department should take steps to stop this practice. Furthermore, the Department should immediately devise protocols that will provide for the safe and appropriate placement of this cohort of young people into foster care.

THE RELATIONSHIP BETWEEN DEPARTMENTS, AGENCIES, COURTS & SERVICE PROVIDERS [4.1–4.1.5]

Local *Child Safety, Health and Wellbeing Partnership*: As argued above,[110] improving service integration and interagency collaboration is fundamental to the task of strengthening Victoria's child protection system. Poor integration amongst the various services that foster the health and wellbeing of children can severely compromise child safety and contribute to poor developmental outcomes.[111] However, despite the generally recognised importance of service integration and interagency collaboration,[112] the current service system does not attain the high levels of service integration and collaboration necessary to protect the safety and wellbeing of children. As argued above, CPS maintains that creating an integrated *Child Safety, Health and Wellbeing Strategy* and local *Child Safety, Health and Wellbeing Partnership* (*CSHWP*s) would do much to improve general service integration and foster a culture of interagency cooperation [see *Recommendation 5*].[113]

Integrating Victoria Police and Child Protection Services: In particular, CPS suggests that there needs to be better integration and coordination between Victoria Police and the rest of the child protection system. For instance, in one case a 4-year-old child alleged to family members, and then again in a police interview, that she has been sexually abused by another family member. Victoria Police decided not to proceed with the matter as they assessed the evidence to be inadequate for maintaining a criminal charge. The evidentiary issue seems to have hinged upon the credibility of testimony given by a 4-year-old and the lack of corroborating evidence. Having made this decision, Victoria Police then dropped the matter. However, even if one allows that Victoria Police were correct in their assessment that the available evidence was insufficient to warrant criminal proceeding, Victoria Police might still have reported the matter to other elements of the child protection system (e.g., ChildFIRST or local specialist child and family services). Lower

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[110] See above, pp.2ff & 2f.

[111] See Victorian Ombudsman, "Own Motion Investigation into the Department of Human Services Child Protection Program", 30ff; and M.O. Bachmann, et al., "Integrating Children's Services in England: National Evaluation of Children's Trusts," *Child: Care, Health, Development* 35 (2009): 257-265.

[112] This recognition extends to its being a ministerial responsibility [see *Child Wellbeing and Safety Act 2005* (Vic) ss.6(1) & 13-16] and to its inclusion in Domestic Violence Victoria's *Code of Practice for Specialist Family Violence Services for Women and Children* (6.8). See also Cooper, Hetherington and Katz, "The Risk Factor: Making the Child Protection System Work for Children", 1ff; and Ilan Katz and Rachael Hetherington, "Co-Operating and Communicating: A European Perspective on Integrating Services for Children," *Child Abuse Review* 15 (2006): 429-439.

[113] Also see above, pp.2ff & 2f.

evidentiary standards apply to these services and the testimony of a 4-year-old would usually be enough to trigger their involvement. In light of such cases, CPS suggests that (i) Victoria Police become members of the proposed local *CSHWP*s [see *Recommendation 5*], and (ii) when Victoria Police decides not to proceed with matters involving children likely to be at-risk of child maltreatment, then the relevant Supervising Sergeant must record what steps - beyond the consideration of criminal charges - Victoria Police have taken to ensure the best interests of the children involved in the case.

RECOMMENDATION 22

When Victoria Police decide not to proceed with matters involving children likely to be at-risk of child maltreatment, then the relevant Supervising Sergeant must record what steps - beyond the consideration of criminal charges - Victoria Police have taken to secure the best interests of the at-risk child.

Integration Models: As already highlighted above, there are a number of models for advancing service integration and collaboration. CPS's recommendation that the Victorian Government establish local *CSHWP*s is partly based on the evidence emerging from US programs like the *Durham Family Initiative* and the *Strong Communities for Children*, from UK's *Children's Trusts*, as well as from such public health models as Victoria's *Primary Care Partnerships* (*PCP*s).[114] Furthermore, CPS suggests interagency collaboration could be improved by tasking local *CSHWP*s with providing professional development in the area of service integration, interagency communication and effective interagency case planning. Establishing trust and effecting mutual understanding between agencies and professions is paramount for improving interagency collaboration.[115] Ultimately, this is achieved through routine collaboration and clear interagency protocols. CPS maintains that, like *PCP*s, local *CSHWP*s are an excellent vehicle for achieving these ends.[116]

RECOMMENDATION 23

When contemplating good service integration models, the Inquiry should consider the *Durham Family Initiative*, *Strong Communities for Children*, the United Kingdom's *Children's Trusts*, as well as public health models like Victoria's *Primary Care Partnerships*. CPS's own integration proposal [see *Recommendation 5*] draws from all of these sources and should be consider as an instrument for providing greater local service integration and coordination within the domain of child safety, health and wellbeing.

THE ROLES AND RESPONSIBILITIES OF GOVERNMENT & NGOS [5.1–5.1.6]

Conflicting Departmental Responsibilities: When it comes to the current configuration of child protection responsibilities entrusted to the Department, CPS believes there is some scope for reform. Despite the recent findings of the *Victorian Law Reform Commission*, CPS agrees with the *Children's Court* when it observed:

> At present the Department performs a number of functions, including the inherently contradictory dual roles of both assisting children and families and initiating and conducting court proceedings involving those same families in child protection cases and sometimes in intervention order cases... Given the conflictual [sic] nature of those two roles, it is not surprising that tensions often exist between the Department and the family members, particularly at court.[117]

Moreover, it is not just the Court but also a significant number of other bodies that maintain that the Department's current set of responsibilities are in conflict with each other.[118]

The current functions of the Department may be summarised and categorised as follows:[119]

(a) Provision of Support Services	• Assisting children and families where children may be at risk of or have suffered abuse. • Working with community agencies and government to assist vulnerable children and families. • Organising and facilitating out of home care for children.
(b) Investigative & Procedural	• Investigating whether a child is in need of protection. • Commencing and conducting proceedings in the Children's Court if the Secretary is of the opinion that a child is in need of protection. • Taking a child into safe custody and bringing that child before the Children's Court if the Secretary is of the opinion that emergency intervention is necessary.

[117] VLRC, *Protection Applications in the Children's Court: Final Report*, 388 (¶10.20).
[118] See VLRC, *Protection Applications in the Children's Court: Final Report*, 388 (¶10.20) & 389 (Footnote #54).
[119] These functions are drawn from the *Children, Youth and Families Act 2005* (Vic). See also, Victorian Law Reform Commission, "Review of Victoria's Child Protection Legislative Arrangements: Information Paper," Victorian Law Reform Commission, 2010, http://www.lawreform.vic.gov.au/wps/wcm/connect/justlib/Law+Reform/resources/d/0/d08b6980417176e48cc59dc23d43cc74/20100211+PACC+Info+Paper+_final_.pdf (2 March, 2010), 4.

(c) Guardianship	• Acting as the custodian or guardian of a child found to be in need of protection when there is no other more suitable person to undertake this role.

In its above statement, the Children's Court argues that the Department's investigative and procedural responsibilities (b) conflict with its other roles as family support provider (a) and guardian (c). In particular, the Court seems to underscore the negative impact this conflict has on child protection workers and the discordant way this conflict plays out in legal proceedings. CPS agrees that the current role of the child protection worker is indelibly fractured by the Department's conflicting responsibilities. That is, workers are forced into the impossibly dual role of both supporting at-risk families and policing them. This is an impossible task because the former role requires a worker to build a relationship of trust and attachment with the at-risk family, while the latter role tends to breed an atmosphere of suspicion, fear and resentment. As such, each role is an antagonist to the other, undermining the other's effectiveness and dispiriting both workers and families. Accordingly, CPS suggests that this duality is at the heart of many of the workforce issues faced by the statutory child protection system.[120]

In addition to the conflicted role of the child protection worker, CPS suggests that these conflicting departmental responsibilities have another potentially negative impact when viewed at a systems level. We maintain that no single system should be tasked with the support and guardianship of Victoria's at-risk children, while at the same time being tasked with the investigative and procedural responsibilities of child protection. If a system has to both determine whether child protection intervention is warranted and then provide that same intervention, and if that system should become stressed under the weight of service demand pressures, then there is a risk that the system will come to require higher levels of child risk and greater levels of child harm to trigger protection proceedings. That is, such a stressed dual system risks shaping the threshold for intervention according to the needs of the support service system rather than in concord with the needs of children. Obviously, such an outcome is unacceptable. Those responsible for assessing whether

[120] See above, p.2ff.

the risk to a child is such that it warrants intervention should be unfettered by any other concerns. They must look only to the best interests of the child and not the interests of the service system, its funding body or its service providers. As such, CPS agrees with the *Children's Court* and the *Victorian Bar Association* that the Victorian Government needs to consider creating an independent statutory commissioner to be responsible for the investigative and procedural responsibilities currently invested in the Department.[121]

RECOMMENDATION 24

The Inquiry should consider the merits of creating an independent statutory commissioner to be responsible for the investigative and procedural responsibilities currently invested in the Department.

[121] VLRC, *Protection Applications in the Children's Court: Final Report*, 390 (¶¶10.20-10.30) & 391 (Footnote #67).

VICTORIAN LAW REFORM COMMISSION REPORT [6.1–6.1.1]

Recommendations of the Victorian Law Reform Commission: While we disagree with the *Victorian Law Reform Commission's* recommendation regarding the conflicting functions of the Department, nonetheless, CPS broadly endorses the recommendations contained in the Commission's recent report.[122] In particular, CPS supports the creation of an *Office of the Children and Youth Advocate* (*OCYA*) and its place in a new procedural system:

(a) In most child protection matters, the *OCYA* will convene a *family group conference* and "assist the parties to reach an agreement that is in the best interests of the child or young person";[123]

(b) "Family group conferences should become the primary decision making forum in Victoria's child protection system";[124]

(c) Unless there are exceptional circumstances, *family group conferences* should be requested by child protection workers, and convened by the *OCYA*, before the filing of a protection application;[125] and

(d) At *family group conferences*, the *OCYA* appoint a child advocate whose function is to represent the best interests of the child in the family group conference and, if required, all subsequent child protection proceedings.[126]

Moreover, we have already suggested that the role of the *OCYA* might be augmented to include a case coordinating role in complex cases [see *Recommendation 10*][127] and an advocacy role for children and young people in residential care [see *Recommendation 19*].[128]

RECOMMENDATION 25

CPS endorses the *Victorian Law Reform Commission's* proposal that an *Office of the Children and Youth Advocate* (*OCYA*) be created. Moreover, CPS suggests that the functions of the proposed *OCYA* could be augmented to include a case coordinating role in complex child protection cases [see *Recommendation 10*] and an advocacy role for children and young people in residential care [see *Recommendation 19*].

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[122] VLRC, *Protection Applications in the Children's Court: Final Report*, 1ff.
[123] VLRC, *Protection Applications in the Children's Court: Final Report*, 382 (Proposal 3.2).
[124] VLRC, *Protection Applications in the Children's Court: Final Report*, 20 (¶1.5).
[125] VLRC, *Protection Applications in the Children's Court: Final Report*, 248 (¶¶7.184-7.186).
[126] VLRC, *Protection Applications in the Children's Court: Final Report*, 375ff (¶¶9.43ff).
[127] See above, p.2f.
[128] See above, p.2ff.

Along with the recommended creation of the *OCYA*, CPS strongly endorses a number of the Commission's other findings. In particular, CPS agrees with the Commission's recommendations for a less adversarial, more inquisitorial and problem-solving construction of the Children's Court:

> The Court should be given a range of powers that encourage and permit it to control the conduct of proceedings by taking an inquisitorial and problem-oriented approach.[129]

In keeping with this approach, CPS is also in concordance with the Commission's positive view of a more expansive use of expert witnesses.[130]

RECOMMENDATION 26

CPS strongly supports the *Victorian Law Reform Commission's* proposal that "the Court should be given a range of powers that encourage and permit it to control the conduct of proceedings by taking an inquisitorial and problem-oriented approach" (*Proposal 2.13*).

Finally, CPS wishes to lend its support to the Commission's recommendations that:

> Every child who is the subject of a protection application should be a party to the proceedings;[131] and
>
> Every child who is a party to a protection application should be legally represented in a manner that takes account of the level of maturity and understanding of that particular child. Two distinct models of representation—'best interests' and 'instructions'—should be available. The two roles and the circumstances of appointment for one or the other (or in rare cases both) should be clearly defined by guidelines. Children represented on an instructions model should:
>
> (a) Have capacity to instruct a legal practitioner, and
>
> (b) Indicate a desire to participate in proceedings by instructing a legal practitioner, and
>
> (c) Indicate an unwillingness to be represented on a 'best interests' basis.[132]

Every procedural effort must be made to protect the best interests of the child and CPS maintains that the proper representation of children's views is essential to the success of this endeavour.

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[129] VLRC, *Protection Applications in the Children's Court: Final Report*, 313 (Proposal 2.13).
[130] VLRC, *Protection Applications in the Children's Court: Final Report*, 316 (¶8.132).
[131] VLRC, *Protection Applications in the Children's Court: Final Report*, 317 (Proposal 2.15).
[132] VLRC, *Protection Applications in the Children's Court: Final Report*, 332 (Proposal 2.16).

RECOMMENDATION 27

CPS strongly supports *Victorian Law Reform Commission's* proposals 2.15 and 2.16. Every procedural effort must be made to protect the best interests of the child and CPS maintains that the proper representation of children's views is essential to the success of this endeavour.

The Law and Children Exhibiting Sexually Abusive Behaviours (SAB): Leaving behind the recommendations of the *Victorian Law Reform Commission*, CPS wishes to suggest that there needs to be much greater clarity regarding which factors determine whether a child accused of SAB is dealt with in accordance with civil procedures [i.e., referral to the *Therapeutic Treatment Board* for a Therapeutic Treatment Order (TTO)][133] or with criminal law. It has been CPS's experience that like-cases involving children exhibiting SAB are being dealt with in different legal fora (i.e., the Family versus Criminal Division of the Children's Court) with radically different outcomes. CPS staff have been unable to discern any legal reason, let alone therapeutic justification, for discriminating between these cases. As such, CPS is left with the impression that such discrimination may amount to arbitrary decision-making.

When criminal charges are laid against a child who has allegedly engaged in SAB, then either the Children's Court or the Department may seek a TTO. When a TTO is successfully sought, then criminal proceedings are suspended until the termination of the TTO. If the child subsequently complies with the terms of the TTO, then the associated criminal charges must be dismissed by the Court.[134] While the body of this process is clear, CPS's concerns relate to how the Children's Court and the Department come to their initial decision to seek (or not to seek) a TTO. On what grounds does the Court or the Department justify their decision to seek a TTO? Under what conditions do they decide that it is inappropriate to seek a TTO and more appropriate to let the Court proceed to hear the criminal charges? If there are no clear principles guiding this decision-making process, or if these principles are not publicly known, then the risk of arbitrary decision-making may arise.

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[133] See the *Children, Youth and Families Act 2005* (Vic), Part 4.8, Division 3.

[134] See *Children, Youth and Families Act 2005* (Vic) and Russell Pratt and Robyn Miller, "Adolescents with Sexually Abusive Behaviours and their Families: Best Interests Case Practice Model," *Department of Human Services*, 2010, www.cyf.vic.gov.au/every-child-every-chance/home (10 April, 2011), 14ff.

Deciding to forgo a TTO application in order to pursue a criminal trial can have significant and adverse repercussions for the accused child. For instance, the court proceedings are themselves traumatic; there is the issue of stigmatising the accused child and, thereby, solidifying abusive behaviours;[135] and there is the possibility that the accused child may be deprived of their liberty and/or placed upon the sexual offender register. There are at least two reasons why these outcomes should be avoided wherever possible. First, insofar as pursuing criminal charges against a child is harmful to the wellbeing of that child, then a decision to try the child may run counter to the best interests principle. The fact that there are allegations against a child does not rescind the state's duty to act in the best interests of the child.[136] Nevertheless, CPS does recognise that in cases of alleged SAB the state may have other duties that conflict with the best interests principle (e.g., ensuring community safety). Where such conflict exists, a balance must be sought. However, at no time is the state permitted to simply disregard the best interests of the accused child. Second, insofar as trying a child accused of SAB may result in solidifying the child's propensity for SAB then the pursuit of criminal charges is counter to good public policy. It may have a positive short-term effect on community safety, while actually increasing long-term community risk. Accordingly, CPS argues that there must be perfect clarity when comes to which factors determine whether criminal charges should be pursued or whether a TTO should be sought.[137]

RECOMMENDATION 28

CPS maintains that there needs to be much greater clarity regarding which factors determine whether or not a child accused of sexually abusive behaviour is dealt with in accordance with civil procedures [i.e., referral to the *Therapeutic Treatment Board* for a Therapeutic Treatment Order (TTO)] or with criminal law.

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[135] Law Reform Commission of Western Australia, "Community Protection (Offender Reporting) Act 2004: Discussion Paper," *Law Reform Commission of Western Australia*, 2011, http://www.lrc.justice.wa.gov.au/3_off_pub.html (10 April, 2011), 112ff. [Hereinafter LRCWA, *Community Protection (Offender Reporting) Act 2004: Discussion Paper*]

[136] LRCWA, *Community Protection (Offender Reporting) Act 2004: Discussion Paper*, 101 & 137.

[137] For instance, the decision-maker may have to consider (i) the relative ages of the victim and perpetrator, (ii) whether or not the sexually abusive behaviour was 'consensual' (in the non-legal sense), (iii) whether or not the sexually abusive behaviour involved physical violence, (iv) the number of alleged offences, (v) whether or not the accused young person has been the subject of previously substantiated cases of sexually abusive behaviour, (vi) whether or not the accused young person has been the victim of child maltreatment (especially sexual or physical abuse), (vii) the likelihood of a therapeutically positive outcome, etc.

Finally, even if the grounds for seeking a TTO are clarified, there still remains the issue of applying these standards to individual cases. Without the input of legal and behavioural experts, the careful application of such standards (e.g., likelihood of a positive therapeutic outcome) to individual cases can become difficult. Accordingly, CPS suggests that the Victorian Government consider changing the *Children, Youth and Families Act 2005* (Vic) to the effect that in all cases in which a child is (a) accused of SAB and (b) charged with associated criminal offences, the Criminal Division of the Children Court must automatically seek a recommendation from the Therapeutic Treatment Board as to whether a TTO is the appropriate way of dealing with the case. Having received such a recommendation, the Court should only set aside the Therapeutic Treatment Board's advice if the Court is satisfied that (i) endorsing the recommendation would involve an error in law, or (ii) there is evidence that the decision is grossly mistaken in its therapeutic reasoning. If the latter is the case, then the Court should refer the matter back to the Therapeutic Treatment Board and require the Board to take account of the Court's concerns. Furthermore, along with its current membership, the *Children, Youth and Families Act 2005* (Vic) should specify that the Therapeutic Treatment Board should include experts in the aetiology and treatment of children who exhibit SAB.

RECOMMENDATION 29

CPS suggests that the Victorian Government should consider changing the *Children, Youth and Families Act 2005* (Vic) to the effect that in all cases in which a child is (a) accused of sexually abusive behaviour (SAB) and (b) charged with associated criminal offences, the *Criminal Division of the Children Court* must automatically seek a recommendation from the *Therapeutic Treatment Board* as to whether a Therapeutic Treatment Order (TTO) is the appropriate way of dealing with the case. Having received such a recommendation, the Court should only set aside the Therapeutic Treatment Board's advice if the Court is satisfied that (i) endorsing the recommendation would involve an error in law, or (ii) there is evidence that the decision is grossly mistaken in its therapeutic reasoning. If the latter is the case, then the Court should refer the matter back to the Therapeutic Treatment Board and require the Board to take account of the Court's concerns. Furthermore, along with its current membership, the *Children, Youth and Families Act 2005* (Vic) should specify that the Therapeutic Treatment Board should include experts in the aetiology and treatment of children who exhibit SAB.

CONCLUSION

As we have already argued, children are essentially engaged in the task of development. As such, the task of protecting children is ultimately the task of guarding and fostering the developmental processes that are at the heart of childhood. CPS maintains that the indivisibility of child safety from the broader objectives of fostering child health, resilience and wellbeing, means that our child protection system must form an integrated part of a broader *Child Safety, Health and Wellbeing Strategy*. The ultimate aim of such a strategy should be the formation developmentally-friendly physical and social environments. A developmental environment is conducive to the safety, health and wellbeing of children when it is characterised by a preponderance of protective factors, the presence of few risk factors, a favourable constellation of the social determinants of health, and an effective legal framework that enshrines and protects the human rights of children and their caregivers. Accordingly, the recommendations contained in the current submission are offered in the hope that they might contribute to the formation of more developmentally-friendly environments for all of Victoria's children.

Finally, CPS wishes to thank the panel for this opportunity to comment on the issues raised in the *Protecting Victoria's Vulnerable Children Inquiry's* terms of reference. CPS values the work of the Inquiry and we wish you well in your important endeavour of securing for all Victoria's vulnerable children the best possible child protection system.

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APPENDIX A – CENTRAL HUMAN CAPABILITIES[138]

Below is the complete version of Martha Nussbaum's list of the central human capabilities:

1. ***Life.*** Being able to live to the end of a human life of normal length; not dying prematurely, or before one's life is so reduced as to be not worth living.
2. ***Bodily Health.*** Being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter.
3. ***Bodily Integrity.*** Being able to move freely from place to place; to be secure against violent assault, including sexual assault and domestic violence; having opportunities for sexual satisfaction and for choice in matters of reproduction.
4. ***Senses, Imagination, and Thought.*** Being able to use the senses, to imagine, think, and to reason—and to do these things in a "truly human" way, a way informed and cultivated by an adequate education, including, but by no means limited to, literacy and basic mathematical and scientific training. Being able to use imagination and thought in connection with experiencing and producing works and events of one's own choice, religious, literary, musical, and so forth. Being able to use one's mind in ways protected by guarantees of freedom of expression with respect to both political and artistic speech, and freedom of religious exercise. Being able to have pleasurable experiences and to avoid non-beneficial pain.
5. ***Emotions.*** Being able to have attachments to things and people outside ourselves; to love those who love and care for us, to grieve at their absence; in general, to love, to grieve, to experience longing, gratitude, and justified anger. Not having one's emotional development blighted by fear and anxiety. (Supporting this capability means supporting forms of human association that can be shown to be crucial in their development.)
6. ***Practical Reason.*** Being able to form a conception of the good and to engage in critical reflection about the planning of one's life. (This entails protection for the liberty of conscience and religious observance.)

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[138] Martha Nussbaum, "Human Rights and Human Capabilities," *Harvard Human Rights Journal* 20 (2007): 23f. [See http://www.law.harvard.edu/students/orgs/hrj/iss20/nussbaum.pdf]

7. ***Affiliation.***

   A. Being able to live with and toward others, to recognize and show concern for other human beings, to engage in various forms of social interaction; to be able to imagine the situation of another. (Protecting this capability means protecting institutions that constitute and nourish such forms of affiliation, and also protecting the freedom of assembly and political speech.)

   B. Having the social bases of self-respect and non-humiliation; being able to be treated as a dignified being whose worth is equal to that of others. This entails provisions of non-discrimination on the basis of race, sex, sexual orientation, ethnicity, caste, religion, or national origin.

8. ***Other Species.*** Being able to live with concern for and in relation to animals, plants, and the world of nature.

9. ***Play.*** Being able to laugh, to play, to enjoy recreational activities.

10. ***Control over One's Environment.***

    A. Political. Being able to participate effectively in political choices that govern one's life; having the right of political participation and protections of free speech and association.

    B. Material. Being able to hold property (both land and movable goods), and having property rights on an equal basis with others; having the right to seek employment on an equal basis with others; having the freedom from unwarranted search and seizure. In work, being able to work as a human being, exercising practical reason and entering into meaningful relationships of mutual recognition with other workers.

APPENDIX B: RISK & PROTECTIVE FACTORS FOR CHILD MALTREATMENT[139]

Ecological Level	Risk Factors	Protective Factors
Child	▪ Age ▪ Gender ▪ Premature birth, birth abnormalities low birth weight, toxic exposure *in utero* ▪ Poor health or disability ▪ Antisocial peer group ▪ Difficult temperament or behaviour ▪ Indigenous identity ▪ LGBT identity	▪ Birth order – first born ▪ Good health ▪ Highly active – multiple interests & hobbies ▪ Good temperament - positive, precocious, inquisitive, willing to take risks, optimistic, altruistic, independent, etc. ▪ Meets developmental milestones ▪ Self-concept – high self-esteem, internal locus of control, ability to give and receive love and affection ▪ Perceptive – adeptly assesses dangers & avoids harm ▪ Interpersonal skills – able create & maintain meaningful relationships, assertive, social competent, able to relate to both children and adults, articulate ▪ Cognitive skills – ability to focus on positive attributes & ignore negative ones ▪ Intellectual abilities – high intelligence and excellent academic achievement
Caregiver/Family	▪ Poverty & low Income ▪ Sole parent or blended family ▪ High number of children ▪ Unrealistic expectations and inaccurate beliefs regarding child development & behaviour ▪ Impulsivity, anxiety, depression, or tendency toward anger ▪ Low tolerance for frustration ▪ Feelings of insecurity or parental incompetence ▪ Prior history of child maltreatment ▪ Adolescent/Inexperienced mother ▪ Mental illness ▪ Substance misuse ▪ History of committing intimate	▪ Structure – rules & household responsibilities for all members ▪ Family relationships – coherence & attachments, feelings expressed openly ▪ Caregiver factors – supervision of children, strong attachment to at least one caregiver, warms and supportive relationship, abundant attention during the 1st year of life, agreement between caregivers n family values & morals, emotional availability ▪ Social support & nurturing relationship with alloparents (e.g., grandparents, aunts, uncles, family friends, etc.) ▪ A positive relationship with at least one non-parental adult ▪ Reciprocity in relationships

[139] *Table 1* is an edited and expanded form of the work of Peter J. Pecora. See Peter J. Pecora, "Child Welfare Policies and Programs," in *Social Policy for Children and Families: A Risk and Resilience Perspective*, edited by Jeffrey M. Jenson and Mark W. Fraser (Thousand Oaks, London, New Delhi: SAGE Publications, 2006), 31f.

	partner abuse ▪ Caregiver stress ▪ Social isolation	▪ Family size – four or fewer children spaced at least two years apart ▪ Middle to high socio-economic status
Child-Caregiver (*Goodness of Fit*)	Poor fit between child traits/behaviour and caregiver traits/behaviour	▪ Good fit between child traits/behaviour and caregiver traits/behaviour
Neighbourhood	▪ Poverty & low Income ▪ High cost of housing ▪ Inadequate housing ▪ Lack of access to medical care, adequate childcare, & social services ▪ Local unemployment rate ▪ Level of concentrated poverty ▪ Poor use of public space ▪ Lack of social cohesion & collective efficacy ▪ Residential instability ▪ High level of violence ▪ High toleration of violence ▪ High per capita density of alcohol outlets	▪ Positive peer relationships ▪ Many opportunities for education, employment, growth and achievement
Cultural/Societal	▪ Social & cultural norms that promote or tolerate corporal punishment ▪ Social & cultural norms that promote or tolerate violence ▪ Social & cultural norms that promote or tolerate gender discrimination and inequality ▪ Social & cultural norms that promote or tolerate racial discrimination and inequality ▪ Social & cultural norms that are disrespectful of child and caregivers ▪ Lack of adequate laws protecting the rights of children	▪ Social & cultural norms that are intolerant of corporal punishment ▪ Social & cultural norms that are intolerant of violence ▪ Social & cultural norms that promote gender equality ▪ Social & cultural norms that promote racial equality ▪ Social & cultural norms that are respectful of child and caregivers ▪ Adequate laws protecting the rights of children

APPENDIX C: THE SOCIAL DETERMINANT OF HEALTH[140]

SOCIAL DETERMINANTS OF HEALTH	
(1) Social Gradient: (a) Income (b) Education (c) Unemployment & Job Security	(5) Employment (6) Working Conditions
(2) Stress	(7) Housing
(3) Early Childhood Development	(8) Social Support
(4) Social Exclusion	(9) Addiction
(5) Race & Culture: (a) ATSI (b) CALD	(10) Healthy Food & Food Security (11) Transport Policy
(6) Gender	(12) Health Services

[140] The list of the *Social Determinants of Health* is compiled from (a) World Health Organization Regional Office for Europe, *Social Determinants of Health: The Solid Facts*, 2nd Ed., ed. Richard Wilkinson & Michael Marmot (Denmark: World Health Organization, 2003) [Find at http://www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf]; (b) Juha Mikkonen and Dennis Raphael, "Social Determinants of Health: The Canadian Facts," *The Canadian Facts*, 2010, http://www.thecanadianfacts.org/index.html (12 January, 2011); Australian Medical Association, "Social Determinants of Health and the Prevention of Health Inequities," *Australian Medical Association*, 2007, http://ama.com.au/node/2723 (16 January, 2011).

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