Dear Convenor,

Please find below a private submission from myself which I would respectfully like to provide to the Inquiry.

I work as a Social Worker across several employment locations, namely, the Emergency Department of the Royal Children's Hospital, Maroondah Hospital and as a Case Analyst with the Child Death Inquiry Unit within the Office of the Victorian Child Safety Commissioner. I am about to complete a PhD study of intervention strategies with children and families where child neglect is an issue. The points of my submission are outlined below.

- Medical Assessment - I am aware that DHS currently relies on obtaining access to Medical Practitioners and Specialists when a medical opinion or assessment is required. This arrangement often fails when no such consultative practitioner or specialist is available, particularly after hours. Consequently, the appointment of a DHS funded Consultant located within the Emergency Departments of Paediatric hospitals would facilitate this service regardless of the time of the request. The VFPMS service is on an on call basis but staff are often not always available at the time so children and families have to wait in an Emergency Department for long periods or return the next day for an examination.

- Disabled Children - Having been involved as a Child Death Inquiry Case Analyst with a disabled child, I am aware of the unclear relationship between Child Protection and Disability Services. One of the major problems seems to be identification of who which party holds case management and who is responsible for decision making concerning the interventive case plan that is required for the child.

- Training - The establishment of the dedicated Child Protection Curriculum at La Trobe University (a joint collaboration between this University and DHS) will contribute to the raising of the profile of child protection work and provide knowledge and the opportunity for skill development in working with vulnerable children and families in this statutory capacity. This curriculum must include a component focused on Aboriginal and CALD children and their specific needs. Additionally, focus must turn to enhanced and targeted training in Child Protection, Child Abuse Review Panels and any initiatives that will promote a more knowledge sophisticated workforce in Child Protection, with higher qualifications for entry, guaranteed quality supervision and opportunities for Child Protection workers to learn from and share with other relevant disciplines.

- Interpreter Services - The responsibility for the provision of and payment for interpreter services in a paediatric Emergency Department is unclear, particularly after hours. Clarity needs to be developed as to whether the hospital is responsible for engaging an interpreter for an interview or whether Child Protection should provide interpreters when they attend to interview a child and/or family in respect to protective concerns.

- Child FIRST Referral - The variance between Regions in respect to Child FIRST referral processes is difficult. For example, some Regions will only accept a written and faxed referral whereas others want a telephone conversation with the referrer. This is particularly difficult if it is after hours and the Social Worker in the Emergency Department of a Paediatric hospital will not be on shift for another few days. To overcome any delay, quite often the Emergency Department Social Workers make the referral from home in their own time the next day.

- Child First Service Provision - The blockage to the acceptance of referrals and the commencement of service provision by Child FIRST to vulnerable children and families is a major concern and often forces children and families into the Child Protection response stream. This outcome is particularly concerning when it is known that Child FIRST was established to prevent this.

- The Co-Location of Services - that are required by vulnerable children and families is strongly recommended in the current child maltreatment and child neglect literature. The rationale underlying this is the recognition that the needs of vulnerable children and families are complex, long standing and cross multiple service systems (for example, child protection, family support, early childhood, maternal and child health, education and housing to name just a few).

- Cumulative Harm - is a concept that has been included in the legislation (Child, Youth and Families Act 2005) and this is a very positive development. Nevertheless, it would appear that the concept is often not fully understood by practitioners of various health and welfare disciplines so I would suggest that more public and professional education by DHS is required to promote an understanding of the underlying principles and the practice implications in investigating and responding to the protective needs of vulnerable children.

- High Risk Adolescents - The presentation of this client group to any Emergency Department is particularly difficult to respond to because of the severe limitations of access to immediate Mental Health assessment facilities. This assessment would help to decide if the adolescent's immediate care need is a mental health or child protection response/facility.

- A Multidisciplinary Case Review Process - should be established in cases where re-abuse has occurred. It seems tragic that the only cases where this is carried out are those in which the child has died.

- Out of Home Care - even though case management often passes to the foster care agency from Child Protection, legal responsibility remains with Child Protection. Consequently, copies of any Statutory Orders and contact details for relevant Child Protection staff should be made available to Emergency Departments by the foster care staff. Additionally, Emergency Departments should have rapid and full access to the conditions of any Statutory Order so that the hospital staff can know who is permitted to have access to the child and who can provide consent for treatment. In the absence of this information, contact often has to be made with After Hours Child Protection and it has been my experience that After Hours does not always have access to this regional office information, particularly if the Statutory Order has only recently been made.

- Children With Higher Needs - I would recommend that DHS should maintain involvement with and responsibility for these children until they reach 21 years of age, as it takes considerable time and effort for the transition to adult services to become effective.

- Interdisciplinary Teams - are imperative in working with vulnerable children and families whose needs span many service systems. A model currently being implemented in Victoria is that of Multi Disciplinary Centres for co- locating multidisciplinary teams of SOCIT Detectives, CASA Counsellors and Child Protection Workers. The purpose of these Centres is to work with all adult sexual abuse victims and child abuse victims of physical and sexual assault. These Centres have come into fruition in Mildura, Geelong and Frankston. An expansion of these Centres to all Regions is recommended.

- Family Court and Child Protection intercollaboration is vital especially where there are Orders in both jurisdictions regarding a child. Children's Court Orders must always hold precedence over Family Court Orders. Both Orders need to list the medical requirements of the children named in the Orders.

- Children's Court processes are still too adversarial, despite legislative attempts to change this focus. Much of this culture comes from the training of Magistrates and legal personnel. Such an approach is warranted in severe cases but it can be detrimental where the child is to remain with the family and the focus is to work with these families for the protection of their children.

- Family Centres - this concept is promoted in much of the current child neglect and child maltreatment literature. These Centres would provide a "drop in" atmosphere where vulnerable

families could attend as needed, even on a daily basis, for such assistance as parenting advice, cooking assistance, laundry facilities, homework tutoring, play facilities and counselling. Centre staff would be on hand during daylight hours to assist families with these daily living tasks and the children and families would benefit from interaction with other children and families, as well as development of the skills required to care adequately for children. These Centres are also seen as having potential to act as a "crisis breaker" so problems do not develop to the point where families need re referral to Family Support or Child Protection Services.

Thank You,

Ronda Johns,

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29th. April, 2010.