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Protecting Victoria's Vulnerable Children Inquiry
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Submission from the Centre for Adolescent Health,

Royal Childrens Hospital, Melbourne

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Introduction

The Centre for Adolescent Health welcomes the opportunity to contribute to this important inquiry. Those participating in the development of this submission come from the broad range of clinical and research health professionals at the Centre for Adolescent Health.

This submission contains a significant amount of information, with reference to published materials we would be happy to provide on request.

We would be delighted to have the opportunity to meet with the panel to discuss in more detail information contained within the submission, or more broadly to discuss the important issues addressed by the Inquiry. This would best be arranged through Dr Rob Roseby (rob.roseby@rch.org.au) and we would request as much notice as possible for a meeting date so as to enable the relevant people to make time in their schedules.

Child protection systems typically tend to focus on harm and risk of harm rather and need and vulnerability. With harm as a focus, it is understandable that those who require the greatest care, the young and those with disability or illness are probably at highest risk. Our observation is that adolescents generally fall into the 'too hard basket' for such systems, not just because they are at lower risk of perpetrated harm but also because there is a scarcity of services for them and with increasing age and ability to contribute to their own problems there may be some bias against caring for them despite their vulnerability. Although we have experience with the systems and determinants affecting younger children, this submission concentrates on issues pertaining to young people of secondary school age.

If it would be useful for the inquiry panel we would be happy to forward more in depth case studies, on the condition of confidentiality of course.

Contents

The Royal Childrens Hospital (RCH)

The RCH is recognised as a world leader in the provision of healthcare to children and young people. The RCH has a long history of working with child protection services to support vulnerable young people and their families. We offer a broad range of primary, secondary and tertiary health services to young people who are at high risk of poor health and wellbeing outcomes. As individual clinicians we are all aware of our obligations to children and interact with the child protection system to a greater or lesser degree around individual children. We are aware of the complexity of health and wellbeing, social and psychological, not to mention cultural issues at play in individual children. We are also aware of the enormous complexity of the child protection system that it is an incredibly difficult job to work in this field.

The RCH comprises three campus partners: hospital, the University of Melbourne and the Murdoch Childrens Research Institute. The relationships between the institution providing service (hospital), and the two teaching and research institutions mean that we have a strong understanding of the link between evidence and practice. We have a body of intellectual knowledge used to inform investment in policy and service provision locally, nationally and internationally.

We have a growing understanding of issues pertaining to Indigenous health and wellbeing.

The Centre for Adolescent Health (CAH)

The Centre for Adolescent Health (CAH) is recognised nationally and internationally for its commitment to advancing young people's health and wellbeing. We are renowned for our understanding current issues affecting young people by way of our clinical services, significant research contributions, development and delivery of teaching programs.

At an international level we are recognised for leadership in the field of adolescent health and wellbeing. We have personnel who act as consultants and advisors to the World Health Organisation, running or contributing to education programs in several countries, largely in the Asian and Pacific Region.

Within the Centre for Adolescent Health is a cluster supporting high risk youth (HRY). . Within this cluster sits a clinical service to juvenile justice (the Adolescent Forensic Health Service), and to

homeless young people (Young People's Health Service), in addition to our clinical service providing general medical services.

The Adolescent Forensic Health Service (AFHS) has provided health services to people aged 10-21 years in the Youth Justice system in Victoria since 1999. At AFHS we undertake to provide the highest quality health and rehabilitative services for young offenders with the vision of making a difference to young peoples' wellbeing. AFHS' multidisciplinary team of over 25 EFT includes nurses, medical officers, psychiatrists, psychologists, social workers, dual diagnosis clinicians, health promoters, criminologists and creative arts therapists, with an holistic approach to health care. We treat every young person as an individual, understanding they often have complex needs. We work with young people to improve their health, reduce risk taking and offending behaviour and help them take responsibility for their lives. AFHS works closely with a range of stakeholders to assist direct care services, build capacity of forensic health services, advocate for the needs of vulnerable youth and contribute to research and development in the youth justice field.

The Young People's Health Service (YPHS) is the only primary health care service that specifically works with young people who are experiencing homelessness and/or marginalisation. It is collocated with a number of other services such as youth law, substance abuse, housing, family link up and others in King St, Melbourne, in a builing owned by the Melbourne City Mission. Funding for this service comes predominantly from the Victorian Department of Health.

Our inpatient and outpatient medical services at the RCH campus treat young people aged 12-19 for a variety of medical problems, and our broad approach is to see medical problems on a background of not only other medical factors but also developmental stage, family, education, psychological, social and cultural context. Our service is interdisciplinary comprising clinicians with expertise in paediatrics, nursing, psychiatry, psychology, social work, education, youth work, music therapy and we have access to other specialty services within the RCH. We are aware of the rights of young people to contribute to or make decisions affecting them, within a framework determined by cognitive ability, developmental stage and various laws. We have a peer support program for young people with significant chronic illness, ChIPS. Youth participation is incorporated in our practice and decision-making processes via a youth advisory committee, YAK (youth at the kids).

Our clinicians have frequent contact with the child protection system including Secure Welfare, the child and adolescent mental health system, as well as community organisations dealing with young people. We work collaboratively with numerous government and non-government agencies in this field.

We have Federal Government funding 2011-2013 for a paediatric trainee in the field of High Risk Youth currently comprising work at the Adolescent Forensic Health Service, Young People's Health Service, and Victorian Aboriginal Health Service.

Adolescents in society

There are differing definitions of what we understand to be adolescence. The World Health Organization (WHO) defines it as the age group 10- 19 years, with youth defined as those aged 15-24. These age groups are often conflated with the unifying term 'young people' referring to those aged 10- 24.

There is further differentiation in the peer review literature into early adolescence (10–14 years), mid adolescence (15–19 years) and early adulthood (20–24 years). For the purposes of this submission we consider adolescence as the developmental stage roughly equating with the age at which Victoria's children attend secondary school, being 12-19 years.

Australia is a signatory to the legally binding United Nations Convention of the Rights of the Child, which recognises that 'childhood is entitled to special care and assistance' and that "the child, by reason of his physical and mental immaturity, needs special safeguards and care..." Article one of this declaration defines the child as a person 'below the age of eighteen years'. Why then in practice does our system for protecting children not accept responsibilities for young people aged 16 or 17? Mandatory reporters are obliged to report where there are significant protective concerns regarding young people to the age of eighteen(1), yet our experience overwhelmingly is that the system will not act on referrals for young people from the age of 16, and sometimes for those who have turned 15 because they are approaching their 16th birthday.

Articles 3.3, 19.1 and 20.1 describe the responsibilities of agencies such as those for protecting vulnerable children. They state in part that

> 'the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.'

> 'States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.'

> 'A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.'

Other articles of the convention discuss aspects of health and wellbeing which highlight obligations we as a society have towards young people to the age of eighteen, especially those with special needs. Among these are also obligations we have towards young people who come into contact with the justice system.

The social role of young people has changed and will continue to change over time. For example, compared with the 1950's young women's social roles of completing education, partnering and

having a first child have stretched from the period 16- 20 years to 18- 28 years currently. Families recognise this change in social transitions, with young people staying at home longer with greater dependence on family support. However, these changes are not recognised by service providers responsible for nurturing vulnerable young people. Community supports are required for longer now than they perhaps were several decades earlier. This is entirely consistent with our understanding of how young people mature and the biological basis for this, with not just cognitive but also structural brain development occurring into the early 20s. This understanding helps to explain why some behaviours prevalent in the teenage years extinguish in the early to mid 20s, but also highlights that vulnerability of young people does not stop at what is defined at the end of childhood (eighteen years) and certainly not at the age at which the statutory response system seems to lose interest (sixteen years).

Recommendation: that the system for protecting Victoria's vulnerable children reiterate that their client base is young people below the age of eighteen years.

Adolescents in the child protection system

Adolescents are a small proportion of the case work of the child protection system. Our perspective is that adolescents are under-represented because:

- There appear to be policies to exclude adolescents from the child protection system. For example our experiences suggest:
  - A young person placed with extended family will be discharged from the system at the age of 16 regardless of the need for ongoing protection.
  - Acceptance of referrals to the child protection system ends at the age of 16
  - Despite the age of 18 years for mandatory reporting there is 'decreasing age creep', in that referrals of 15 year olds are not readily accepted because a young person is approaching the age of 16.

In contrast to younger children where physical causes such as chronic diseases, neurological and developmental disorders are the major burdens of disability, in adolescents the greatest burden lies in the sphere of mental illness, particularly anxiety and depression, Attention Deficit and Hyperactivity Disorder (ADHD) and autism spectrum disorders, among others. Adolescents, as well as those in other age groups with mental health disorders are less likely than those with physical disorders to be viewed with sympathy and support. Some argue those with mental health disorders suffer discrimination in society, and perhaps a child protection service which itself neglects individuals with such problems adds institutionalised discrimination to the problems they face.

Our perspective is that this age group may be seen as too difficult, and the child protection system probably breathes a collective sigh of relief when they can rid themselves of these young people who remain Victoria's most vulnerable

Vulnerability- health and wellbeing issues, lack of access to services; our observation at AFHS and YPHS is that there are higher rates than expected of chronic disease, developmental issues, intellectual impairment, congenital disorders such as genetic and chromosomal syndromes, etc.

A recent publication in the Medical Journal of Australia describes the burden of disability in young Australians. 'Mental disorders are the largest "contributor" to disability in 10-24 year olds', with a burden of disability more than twice that of the next most prevalent physical cause. Anxiety and depressive disorders combined are the leading single cause, with a similar burden of disability resulting from autism and attention deficit hyperactivity disorder combined. In young females, eating disorders are the second leading cause of mental disorder disability, particularly in the age group 15-19 and older, where these conditions alone are still more prevalent and cause greater burden of disability than do any single physical cause. Schizophrenia begins to emerge in this age range as an important contributor, with alcohol use disorders emerging similarly, more so in males than females.(2)

Death rates are a somewhat blunt but objective and easily measured outcome. Globally, we celebrate the falling rates of death in childhood but note a change in the age groups at highest risk (see graph below). A landmark Lancet publication published in 2011 examined deaths in people aged 1-24 (ie excluding infant mortality) over the last 50 years across economic spectra and continents. It finds all cause mortality falling sharply as a result of reductions in infectious disease mortality. The slowest decline in death rates has been in the 'older adolescent' and 'young adult' age range (15-24), where deaths have reduced by about 50% compared with the younger age groups where deaths reduced by 80-90%. It will be surprising to most to find that from the start of this millennium death rates in males aged 15-24 have exceeded those of males in the 1-4 year age group (see graph below). What this means is that the likelihood of a male dying aged 15-24 is more than twice the likelihood of him dying in the next highest risk age group, ages 1-4. This evidence demonstrates the exact opposite of what is commonly understood. In females the rate of death in these two age brackets is similar. For young people aged 15-24 the most common causes of death are transport accidents, violence, homicide and suicide. (3)

A major contributor to why adolescents have an increased vulnerability to poor health and wellbeing outcomes is that they are less likely than younger children to have protective factors in place. For example, while a young child is at greater risk than an adolescent if they are homeless, the adolescent is far more likely to be homeless than the younger child. Similarly, an adolescent is far more likely to not engage with school than a primary school age child.
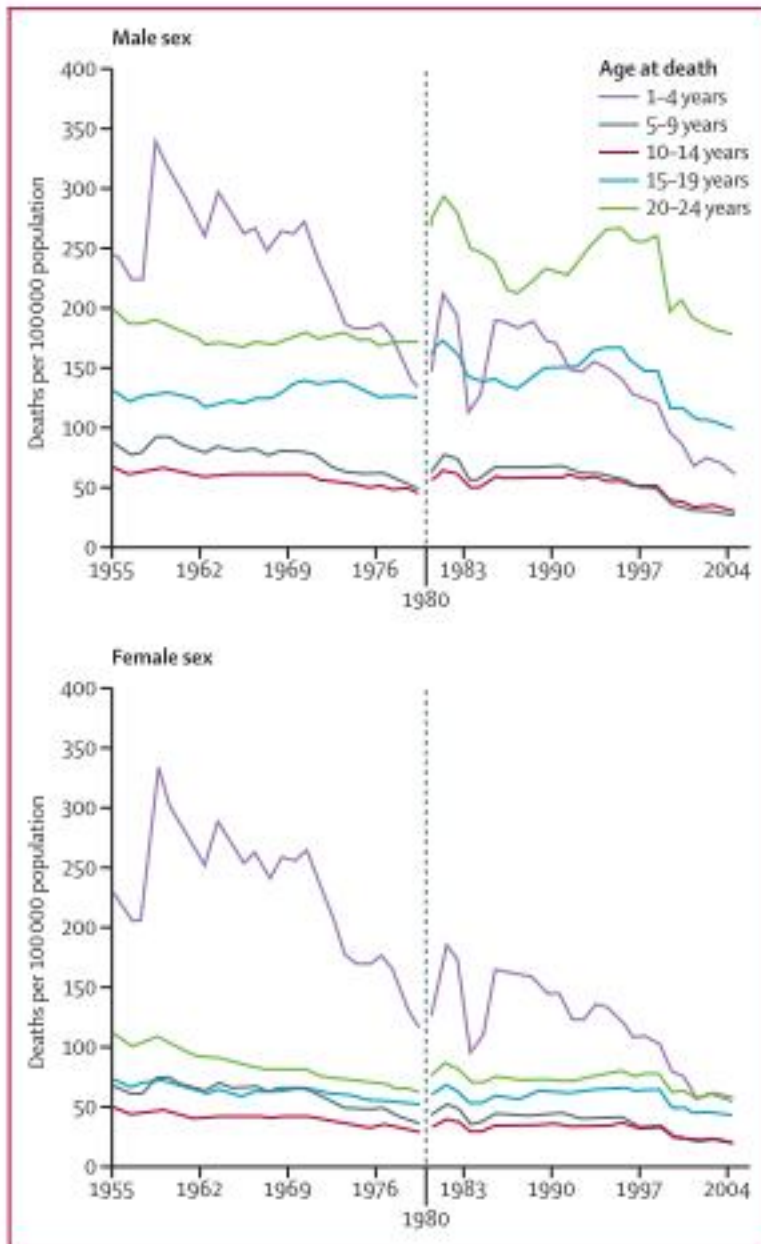
Figure 2: All-cause mortality per year from 1955 to 2004 by sex and age-group for all participating countries
A discontinuity is shown at 1980 because of entry of eastern European countries and ex-Soviet states into the cohort.

(3)

The Victorian Government through the Department of Education and Early Childhood Development (DEECD) should be applauded for collecting information via anonymised surveys regarding a number of child and adolescent wellbeing indicators, the Victorian Child and Adolescent Monitoring System (VCAMS). Among other things VCAMS examines outcomes including related to adolescent perceptions of family, peers, school and community issues. (4)

Recognising that the large amount of data the Government holds is not sufficient for reporting against VCAMS, DEECD commenced a series of surveys to collect additional information(4). The Victorian Adolescent Health and Wellbeing Survey is a school-based survey capturing information from over 10,000 adolescents, commencing in 2009. It can provide reliable data by local government area in the Melbourne metropolitan area and in other regions within the state. Such data provide evidence for effective and efficient allocation of resources and setting of appropriate priorities. They can guide efforts at primary prevention (ie before problems occur), secondary prevention (where adolescents are at higher risk of disengagement) or treatment interventions. 'Hot spots' may be identified where there are high rates of violence, educational disengagement or substance use, for example. (5) Because this approach relies on enrolment at school it will not capture data from those who have already disengaged from formal education. It may be useful for the inquiry panel to look further into what data is available and how the state or local governments plan to use it.

Outcomes

Young people who have been in state care and protection are significantly over-represented in the homeless population. The Centre for Excellence in Child and Family Welfare submission to the 2010 Victorian Inquiry into public housing notes 'in the 2006 census of homeless people, 15% of homeless school students had been in care'. They cite other studies documenting local data including from 2008, where a survey of 5,056 homeless people found that 30% were aged under 18, and nearly half had been in state care at some stage in their lives (6).

That such an alarmingly high proportion of the homeless population are graduates of state care demonstrates something is drastically wrong with the system. Some argue that those who are requiring care until adolescence are likely to have experienced serious disadvantage which puts them at risk of such adverse outcomes anyway. This is true but these data should dispel the fanciful notion that the state can effectively act as a 'public parent'. It has never been able to act in this way from the earliest welfare efforts in London in the mid 1760s when 57 of 59 infants taken into care died within two years (7). The two lessons to be learned from these two welfare disasters separated by 250 years is that taking young people into 'care' is not sufficient and should be the option of the very last resort, and also that for those for whom there is no alternative to out of home care, significant investment is required for those leaving it.

There is considerable crossover between the justice system and child welfare. Our understanding is that in Victoria diversion programs have been successful in keeping young people out of the justice system, with a focus on support in the community. We understand this to result in a lower rate of recidivism, with significant benefit to the community resulting from this. We also understand these diversionary programs are constantly under threat, with reliance on political support which may not necessarily be grounded in evidence. Outcomes for graduates of the juvenile justice system are alarming, with the mortality rate within three years of release from gaol for males being nine times that of the community age-equivalent baseline. (8)

The Supported Accommodation Assistance Program provided accommodation assistance to 125,800 people in 2008-9. The annual report for this period reveals that fewer than half of those accessing this scheme in Victoria were assisted with health services (5.3%) compared with NSW (12%), the state with the highest rate of assistance into health (9). When other categories we would consider to be health (for example, psychological, pregnancy and sexual health related services, etc) are taken into account, the rates are 13.8% for Victoria and 25.3% for NSW. This strongly supports our observation that the burden of health needs among this vulnerable group is large, with one person in four in this program in NSW receiving health support, but also that there is a huge unrecognised health need in Victoria among the population requiring accommodation assistance.

Journey to Social Inclusion is a collaborative action research project conducted by RMIT University and Sacred Heart Mission which has surveyed 84 homeless people of average age 36.5 years. Of their participants 53% reported sexual abuse when growing up and 38% had been in state out-of–home-care. 42 % have children under 18 and 68% have children who have spent time in state out of home care.(10)

Youth workers: a valuable resource but also a missed opportunity

The discipline of 'youth work' is important. It is about empowerment of young people to have influence and control over their lives, focussing on rapport, support, connection and social engagement. Youth workers can connect with young people in a skilled way, forming alliances which are powerful particularly for some young people for whom such alliances are missing elsewhere in their lives.

This discipline is evolving. At this point in its life cycle there appears to be a perception among some of its workforce that identification with the client group is paramount, to the exclusion of any identification with the mainstream. There are some within the sector dealing with high risk youth who seem to believe that participating in an assessment of young people at risk is in some way identifying as part of a punitive system, and thereby do not participate in it. The problems which arise from this are mainly in the domain of opportunity cost.

- The workforce in this field has significant access to young people in all manner of environments but does not use this access in a manner of maximum benefit to young people.
- If workers in the field are not willing or able to undertake the most basic assessments then referral for therapeutic interventions cannot occur.
- It is unclear to us whether or not youth workers are sufficiently trained to identify even the most common mental health issues which present in the youth age group and to know what referral pathways to pursue
- The lack of regulation in this field means any one can call themselves a youth worker, whether they have a Bachelor of Youth Work degree, or no formal training at all.
- Without regulation workers in this field rely on the governance of their organisations to provide standards of knowledge, skills and practice. Our experience is that this is extremely variable.

There are deficits in the service sector around therapeutic interventions for mental health, alcohol and other drugs. This may contribute to reluctance of youth service providers to perform assessments, given that entering this space with young people entails the risks associated with opening a line of painful inquiry without knowing where it will lead and without necessarily the skills to deal with what is found there.

However, this notwithstanding we recommend that the Department of Human Service explore the field of youth work with a view to regulation. Building youth work as a profession would entail among many things standards around training and education, knowledge competencies should issues such as mental health, housing, legal issues affecting young people as well as developing further a culture around therapeutic intervention as part of not separate from the service sector.

Training and education for those working with young people

One of the Inquiry's terms of reference refers to 'measures to enhance the government's ability to… ensure a workforce that delivers a service of high quality to children and families'.

While the youth worker sector needs consideration given to the future training of its workforce, the question needs to be asked how equipped we all are as professionals in the health and wellbeing sectors dealing with adolescents. There are not many training models, and even our own High Risk Youth paediatrician trainee in 2011 is the first of its kind nationally.

Within our own hospital we are developing a graduate nurse training program in High Risk Youth nursing. We have the will and ability to implement such a training program in youth and high risk, but are struggling for the funding required for the trainers and supervisors currently.

The Centre for Adolescent Health already plays a role in workforce and professional development by way of a providing a three-tiered postgraduate program adolescent health and welfare; Masters / Graduate Diploma/ Graduate Certificate in Adolescent Health and Welfare. This popular course has been running since 1995 through the University of Melbourne. Participants come from a variety of disciplines, including nursing, medicine, allied health, teaching, police, counselling and youth work. Many have had roles in juvenile justice, protective services, secure welfare, homelessness, outreach or other services for high risk young people. Although highly skilled in their respective disciplines, feedback consistently tells us that studies focusing on adolescents, their developmental needs, their psycho-social vulnerabilities, evidence-based practice, the need for improved cross sectoral practice has had a profound impact on their work with young people, at both the personal level and the systems level. We are currently exploring the opportunity of a scholarship for a student working in the high risk area.

The next step in evolution of our training programs is modelled on the *Leadership Education in Adolescent Health (LEAH)* program in the USA (11). This provides interdisciplinary training for doctors, mental health professionals, nurses, social workers, and nutritionists and aims to develop 'public policy and public health experts, and train clinicians, investigators and educators'. To perform

this role we would require funding for a 5-year pilot program to commence a Masters of Adolescent Health/ senior clinical program or the like.

There are other ways the Centre for Adolescent Health could contribute to the field. It would be helpful if there were funding models to enable our consultant medical staff to provide secondary consultations to other health professionals to help them navigate their clients and patients through the complex care system. We propose that community health centres need paediatricians with better training in adolescent health than exists currently.

It is now time for recognising across sectors the need for specialisation within disciplines in adolescence and high risk adolescents. We can no longer afford nor should our moral conscience allow us to ignore this neglected group.

Comments about the child protection approach versus a public health approach to safety and wellbeing

The forensic approach to child protection relies on identification of child abuse and neglect. In the early days of this field it was necessary to take a case-finding approach given that it was not until the 1970s that the recognition of the need for a state-response to children being harmed by abuse or neglect by the actions or inactions of adults, was translated into action (12, 13). There needed to be and was increased recognition of this phenomenon of abuse and neglect so that cases could be identified, largely in order that the children could be removed from dangerous living arrangements. There is a need for this still, but a system which relies on a case-finding approach will clearly be too late.

What has happened increasingly, particularly in the last decade or so, is an attempt to look more at preventive efforts generally but also on a case by case basis. This is driven by the twin factors of a laudable recognition of the need for intervention before injury occurs, but also by the development of a culture within child protection systems of a culture of risk management within the statutory authority responsible. The risk is not just to the children but also management of risk to the organisation, such that protection of itself and its workers from a community with unrealistic expectations of the authority's abilities to protect children from harm became an important part of their business. It is understandable why this would come about- barely a week goes by without criticism in the media of a statutory child protection authority somewhere in Australia, or a story about a child or young person who suffered harm or pregnancy etc while known to the system. The report of the inquiry into the NT child protection system made this point strongly (14).

If we agree that it does take a village to raise a child, then indeed society has responsibilities toward its most vulnerable children. Every child is born with genetic potential to achieve their best in a number of domains (broadly cognitive, social, and physical) and it is the environment that determines what they will ultimately achieve.

There is no-one more highly qualified nor more highly regarded in the field of a public health approach to protecting children than Professor Scott, and Victoria already leads much of the

Anglophone world with respect to the public health approach to child and adolescent safety and wellbeing. The Child First model is an excellent start to more upstream investment of resources. Its development and evolution has been part of the consciousness-raising that more effort is required at the preventive end of the spectrum of possible interventions to promote safety and wellbeing, an aim subtly different from protecting from harm. However, in practice even the Victorian system is overly focused on harm and risk at the cost of a focus on need and vulnerability of children, adolescents and families.

We do not need to outline in detail the public health model, which takes into account social structural determinants, proximal determinants and mediators resulting in outcomes in domains of health and wellbeing, outcomes which can be future-based as well as present. Rather than revisit these concepts we wish to draw to the Inquiry's attention chapters 3 and 6 of the *Growing them Strong, Together* report (14).

Appendix 1 is a chart looking at the spectrum from determinants through to behaviours, mediators and outcomes from the perspective of adolescence, including the link with the next generation. The challenge is for organisations to use such a chart in order to identify points at which they can offer effective interventions. Much of the focus on adolescents tends to be around the problems and risks rather than opportunities. There is great potential to provide prosocial, prodevelopmental opportunities in many spheres, such as sport, music, arts, etc. Of note, as we become more prosperous as a country the disparities between the mainstream, which continues to improve, and those more marginalised becomes greater.

Terminology:

The words we use to describe something can often determine the response to it. Given that the term 'protection' is so strongly associated with this forensic approach we suggest it be replaced with 'safety and wellbeing', as did the Growing them Strong, Together report from the Inquiry into the NT child protection system(14). We recommend the inclusion of terms such as 'child and young person/ children and young people' We support your Inquiry's use of language like 'vulnerability' and 'need'.

Model of collocated and joined up service delivery

We propose a model of collocated and joined up child, youth and family services similar to the community health services which we understand exist in Queensland and New South Wales but are absent in Victoria. The goal of such services would be to provide holistic, timely, integrated health and wellbeing assessments and interventions for children, adolescents and families. The services in such centres would need to be locally determined but would comprise some or all of maternal and child health nurses, medical services, social work, parenting advice, child protection. Integration with schools is a key requirement of such a service. Interagency communication is always greatly enhanced by collocation of services, and the client almost always prefers to move between collocated services rather than be referred from one to another, preferably without needing to retell their story. Clearly funding models would need to be developed to drive this, with services delivered by either government or NGOs. Elements of care teams at such resource centres would be a suitable

governance arrangement with a high level of supervision by way of team decision-making, a sense of safety within the team, focus on quality, protected by good policy. The medical assessments will clearly require doctors with expertise in dealing with children and expertise in adolescent health.

Issues within the existing statutory system

We wish to make only a few comments regarding the extant statutory system. These comments are restricted to

- Planning for leaving care
- Secure welfare
- The role of the courts
- Recommended outcome measures

Planning for leaving care

The DHS policy document 'Planning for leaving care, advice number 1418, September 2009' is excellent, and if it were followed many of the problems we see with young people leaving care would not occur. Why is it that an otherwise satisfactory policy from the policy and practice manual is so difficult to implement? Is this an issue of workload? Is it an issue of organisational culture?

We would describe the policy on preparation planning (pp4-10 of the document) as exceptional. The domains of health and education, identity, family and social relationships, social presentation, emotional and behavioural development, self care skills including accommodation options are well described. Why then are there so many problems for young people leaving care? Clearly more is needed. After leaving care, the state still has responsibilities toward that individual.

We recommend that every young person leaving state out of home care has:
- A care plan encompassing the departments stated domains of assessment, developed in consultation with the young person, co-signed by the young person
- Access to an ongoing, named case worker as an advocate, contact/ reference person to aid them in:
  - Accommodation
  - Preparation for entering the workforce, including
    - Developing a CV
    - Securing further training and employment
  - Priority access to affordable accommodation
    - With the ability of a government agency to act as guarantor for rent and condition of the property on termination
    - Support packages available to fund boarding (as opposed to voluntary foster care)

Secure Welfare

Secure Welfare represents an opportunity to develop a new model of integrated service delivery to high risk young people in Victoria. We see the need for a more holistic team-based approach which can deliver a timely assessment and plan across disciplines and services, with a lead coordinating

agency. The current tender for a health service does not require any agency to take responsibility for governance.

The role of the courts

We understand the Childrens Court of Victoria, through Judge Grant is interested in developing an intensive management approach to cases of sexual abuse in the family division. This approach involves identification of treatment options, not just than a focus on the requirements of a court to make a finding of fact resulting in conviction and sentencing. Broadening the suite of tools available to the court to include more therapeutic options around context and vulnerability is progressive, warranted and welcome.

Recommended outcome measures

Victoria has articulated a set of outcome measures it sees as important for knowing how children and young people are faring in this state. We recommend the following are added to Victorian Child and Adolescent Monitoring System, or are used as outcome measures evaluating the welfare system in Victoria:

- Tracking life outcomes of those who have been graduates of the child protection system in Victoria. Appropriate indicators would include:
    - Rate of teenage pregnancy (ie births plus terminations)
    - Convictions for offences before the justice system
    - Standardised mortality ratios of those within 36 and 60 months
    - years of those who have been through the child protection system (number and rate)
- Deaths by accident, suicide and violence in age group 12- 25 (number and rate)
- Regardless of the age at which they leave the system, graduates of the child protection system from the age of 12 (number and rate)
    - in housing
    - in education
    - in employment
    - not in employment, education and training
- graduates of the youth justice system at 12, 36 and 60 months of release (number and rate)
    - in housing
    - in education
    - in employment
    - not in employment, education and training
    - Standardised mortality ratios of those within 36 and 60 months of release

Summary of our Recommendations

1. That the system for protecting Victoria's vulnerable children focus on need and vulnerability broadly rather than on acts of abuse and neglect

2. That adolescents be recognised as a high risk group, with needs and vulnerability for which the state has responsibilities, yet which are largely not adequately met.
3. That the language of the sector and system include terms such as 'child and young person/ children and young people', 'vulnerability and need'
4. That the system for protecting Victoria's vulnerable children reiterate that their client base is young people below the age of eighteen years
5. That there is significant investment focused on education regarding the needs of adolescents in order to improve the performance of the sector with this vulnerable and neglected group.
6. That the Department of Human Service explore how best to support the practice of youth work. with a view to regulation.
7. That the default position is that services for adolescents be collocated and joined up.
8. That the department's own 'leaving care' policies be implemented and followed.
9. That outcome measures be adopted in order to measure not just child protection processes but also real outcomes for Victoria's young people.

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Determinants (Risk and Protective Factors)	At-risk (or protective) Behaviours		Mediators	Adolescent health and wellbeing outcomes (current)	Adolescent health and wellbeing outcomes (future)	
Policy Legislation Home Family Parenting Education engagement Peer connectedness/ social inclusion or exclusion Resilience	Eg • School/ training attendance and engagement • Sexual practices • Condom / contraception use • Use of / access to services • Violence • High-risk driving behaviour • Substance use • Eating behaviours and nutritional choices • Social	**Adolescent Health, Development & Behaviours**	Eg • Sexual and reproductive health / STIs / HIV • Physical and Mental health • Accidents • Substance Use (alcohol and tobacco; illicit drugs) • Nutrition • Mental health	Eg Engagement with • Family • School • Friends • Social activities Attitudes to • Society • Rules May be prosocial or antisocial	Eg • social • career • family • financial • satisfaction/ happiness • mental health • etc	**Next generation: neonatal and child health and wellbeing outcomes (perpetuation of cycle)**

Appendix 1: Schema of the public health model as it pertains to adolescents, looking at determinants, behaviours, mediators and outcomes.