Protecting Victoria's Vulnerable Children Inquiry

Submission from
The Victorian Forensic Paediatric Medical Service

29th April 2011

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The Victorian Forensic Paediatric Medical Service (VFPMS) welcomes the opportunity to provide a submission to the Inquiry into Protecting Victoria's Vulnerable Children. We note the terms of reference for the inquiry and the specific questions posed by the Inquiry Panel. We thank the panel for reading this submission and hope that some of our comments and suggestions might prove useful.

The Victorian Forensic Paediatric Medical Service is medical service providing health and injury evaluations for vulnerable and abused children. The core functions of the service are to provide

- face-to-face evaluations of children when neglect or abuse is suspected,
- advice to other professionals in relation to the medical evaluation of suspected child abuse,
- education and training related to child abuse and neglect and
- medical reports suitable for presentation at case conferences and in court.

As the tertiary level forensic health service providing medical evaluation and care to abused and neglected children, VFPMS provides services for many children who are clients of Child Protection. VFPMS has a strong professional relationship with Child Protection and an active interest in enhancing the broader system for improving the quality and safety of children's lives.

Opinion and comment has been canvassed broadly from within the VFPMS. Team members' comments and suggestions are contained in this submission without censorship and are offered in good faith without fear or favour. We are mindful of the fact that some suggestions and comments are not "consensus views" but are none-the-less sincere comments from health professionals "at the coal face" of child protection in a health-care setting.

Responses from the VFPMS team are in relation to the following terms of reference for the panel of inquiry:

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

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

Noting that the prevention of child abuse risk factors is not the same thing as prevention of child abuse per se, VFPMS encourages the inquiry panel to question the effectiveness of strategies aimed at reducing the prevalence of violence in the community, all factors that might impair a parent's ability to function effectively and factors that compound the negative effects of abuse, such as poverty and geographic isolation.

VFPMS encourages the Inquiry Panel to

a) explore the effectiveness of strategies and services aimed to reduce the prevalence of violence in the community.
b) explore the effectiveness of strategies and services aimed to reduce the prevalence of drug and alcohol misuse.
c) explore the effectiveness of strategies and services aimed at early identification and treatment of mental illness; particularly in teenagers and young adults.
d) Research (in Victoria) the effectiveness of strategies such as the period of Purple Crying program[1] aimed at reducing the incidence of infant shaking.
e) explore opportunities for providing parents attending antenatal classes with educational products regarding strategies for building better relationships with infants. Subsequent to this, to evaluate the effectiveness of the use of these educational materials in fostering attachment between infants and their parents.
f) explore the effectiveness of services currently offered to children and families who are or may become marginalized from main stream services eg. Families who are recently arrived immigrants, non English speaking, homeless, disabled, have chronic psychiatric conditions or a history of significant conduct disorders.

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

Immediate

1. Greater use of publicly funded professionals, for example professionals working within the Health, Early Childhood, Education and Housing sectors, to provide immediate support for parents in crisis and early referral of at risk children (direct referral) to community-based intervention services. Modules to be developed for education of these professional groups to encourage and support their role in early detection (of risk of harm to children) and intervention (to prevent or minimise such harms).
2. A policy shift that provides education for, and designates responsibility to, professional groups such as Maternal and Child Health Nurses and General Practitioners encouraging direct referral to non-government parent support agencies, replacing a policy that encourages channeling

[1] National Center on Shaken Baby Syndrome at http://www.dontshake.org/sbs.php?topNavID=4&subNavID=32 accessed 26/4/11

referrals to parent support agencies through Child FIRST. These nominated professionals are likely to encounter "at-risk children' in their day-to-day work and are sufficiently well educated and skilled to provide an accurate assessment of the children's vulnerability and needs. Referral via Child FIRST potentially creates an unnecessary bottleneck that might impede referrals to appropriate services.

Medium

1. Greater public awareness of the need to safeguard children from exposure to violence. A public awareness campaign about the negative effects of exposure to all forms of violence (physical, sexual and emotional)
2. Greater public awareness about the need for children to be protected from the many harmful effects associated with exposure to adults who have problems with drug and alcohol addiction. "Where are their kids?" might be a tag line.
3. Early recognition and treatment of postnatal depression.
4. Develop measures to improve the professionalism and status of child protection workers with the aim of improving morale and staff retention.
5. Evaluate the cost-effectiveness of Working with Children Checks

Long-term

1. Greater community awareness of the developmental and psychological needs of infants and young children (particularly in relation to their need for strong relationships with primary carers (ie attachment) and the need to avoid exposure to noxious events and circumstances such as neglect).
2. Higher priority for policy and government- supported services to meet the needs of infants and young children
3. Encourage adults who are at extremely at risk of having a child removed from their care to voluntarily restrict fertility. (Financial inducements)
4. Greater use of the media to disseminate public health messages
5. Coordinated and collaborative use of non-government organizations to provide support and assistance for parents. Improved governance of NGOs / program evaluation having increased priority and visibility.
6. Collaboration with international agencies in relation to detecting/intervening/preventing child trafficking and sex tourism

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

- Early recognition and intervention of irremediable situations. This particularly applies to decisions made within the Children's Court of Victoria. Earlier permanent care planning is encouraged for children who are at most extreme risk (a small group of children consume a

disproportionate amount of the welfare, Child Protection and Dept of Justice budget).

- Government policy that recognises and values the needs of children; infants and young children. A shift in community attitudes towards a view of children as a community asset seems likely to promote better surveillance of at-risk situations, earlier intervention when situations exceed the "acceptable risk" thresh-hold and more community engagement and effort to assist struggling children and carers.

- Collaboration between professionals working across sectors. Avoidance of duplication of services.

- Ongoing education and support for professionals working in universal services such as maternal and child health nurses, health and educational professionals and professionals working for Centre link.

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

Some appreciation of culturally and geographically diverse populations is required in order to permit flexible approaches to intervention to better support parents. However, the principles that underpin strategies should be the same for all.

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

Benefits
A public health model provides greater emphasis on science and data and less emphasis on theoretical frameworks. This approach lessens the risk that mere politics and emotive argument might drive policy direction and it increases the potential for money to be spent on programs that are of proven effectiveness, particularly in relation to primary prevention.
There is a greater focus on evaluating the effectiveness of primary, secondary and tertiary prevention programs.

Characteristics and benefits
A tiered approach to a complex/wicked problem

A public health model conceptualises the phenomenon of child abuse as having contributing factors that stretch from the harmful situation and circumstances to individual child and adult, through family and neighbourhood, community-based factors to government policy and strategy.

Hence it creates a capacity to identify root causes rather than focus on 'down stream' effects.

It facilitates the recognition of factors that increase the prevalence of a condition within subsections of the community (identify at risk populations) in a non-stigmatising way

It allows for scientific exploration of particular subtypes of child abuse, many of which have differing antecedents and contributing factors.

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

2.1 What is the appropriate **role** of adult, primary and universal services in responding to the needs of children and families **at risk** of child abuse and neglect?

The population of children at risk of neglect and abuse includes large numbers of children who have already been subject to adverse circumstances, neglectful situations, and child abuse. It is an artificial construct to imagine a group of children who are "at risk" but who have not yet experienced abuse or neglect of some sort. It is necessary to consider ALL children eligible for primary prevention, recognizing that some will be in need of secondary and tertiary prevention in addition to primary prevention. It is therefore necessary for universal service providers to be better informed about secondary and tertiary prevention services in order than prompt referrals and better intervention might occur. A general approach should encourage:

- early identification of **risk** with prompt intervention to prevent child abuse/neglect
- early identification of parental circumstances that are already contributing to child neglect and abuse
- responses to support children and families that might obviate the need to engage statutory agencies or NGOs
- two-way exchange of information with statutory agencies
- collaboration with statutory agencies in relation to case planning.
- provision of some of the planned intervention by universal service providers
- monitoring of the child's situation
- engagement of statutory agencies when the situation demands it
- prevention of abuse and neglect sequelae / harm minimisation
- assistance/support for parents /children when children are no longer able to reside in their parent's care

There exists a culture of labelling children as being "at risk" rather than clearly identifying significant neglect at a level that should demand statutory agency intervention

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

- Recognition that professionals working within these services have an obligation to ask about dependent children of adult patients/clients and to evaluate the adult client's capacity to safely and appropriately care for their children
- Surveillance - to recognize situations when adults who are also parents are placing children in jeopardy
- Intervention to reduce the risk of harm to children of adult patients
- Inclusion of a safety plan for dependent children as part of the adult's management plan
- collaboration with statutory agencies
- two-way exchange of information with statutory agencies
- active provision of intervention to better safeguard dependent children of adult patients and clients
- efforts to address the tendency of services for marginalized adults to "protect" those adult clients (who are often regarded as vulnerable or "victims") from engagement with Child Protection services. The desire to advocate for their adult client can, at times, risk over-riding their duty to safeguard the dependent children of that client.

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

Policy statements : Each service should recognise the needs of dependent children of adult patients and clients in their mission statements or similar

Transparency for adult clients regarding limits to confidentiality when children are at risk of harm. Adults should be informed that service providers might refer children of adult clients to Child FIRST and/or Child Protection.

Management adopt policies and practices that foster greater willingness to share information between professionals
Case management plans should be inclusive of the needs of dependent children

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

Immediate

Introduce policy: Organisations (government and NGO) that employ professionals who provide services for adults who may be parents of vulnerable children should introduce policy and guidelines for intervention to better protect children when the children are at risk of harm
Educate professionals – all employees should be aware of policy regarding obligation to consider possible intervention to better protect children of adult clients

Medium
Web-based guidelines (Child Protection site) regarding situations that should alert professionals and members of the public to situations that place children at risk of harm
Eg NSW information fact sheets and Community Services website

Longterm
Challenge the culture and thinking within Child Protection services. Move away from the current focus on crisis-driven responses towards a much more holistic, inclusive and constructive approach that better uses the efforts of professionals from other sectors and the NGO workforce.

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

Education for general practitioners, obstetricians, paediatricians maternal and child health nurses and nurses working in maternity and neonatal wards. (Early identification of the 'at-risk' target group is the first step. This involves far more than identification of "a neighbourhood effect" in low SES suburbs. Better surveillance and a low thresh-hold for parents' engagement in programs to enhance attachment/improve parenting skills and better involvement of extended families and neighbourhood support etc)

Intervention (targeted programs) to minimize or prevent neglect and abuse COUPLED with a high level of awareness of risk and surveillance to detect problems as they arise.

Early and better professional support for young parents with a history of vulnerability, mental illness, drug /alcohol abuse and poor attachment.

Practical support for parents of young children who are living in adverse circumstances (financial / in-home support / child care)

Programs such as "young mothers' groups" and professionals home visiting programs that provide services for high risk young parents / Use of strategies that promote better attachment between parents and infants.

3. The **quality, structure, role and functioning of: family services; statutory child protection services**, including reporting, assessment,

investigation procedures and responses; and out-of-home care, including permanency planning and transitions; and what improvements may be made to better protect the best interests of children and support better outcomes for children and families.

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

This is an admirable approach but a serious gap remains between the idealism of policy and its implementation at the coalface.

The current approach does not go far enough in integrating Health, Education and other professional groups into the broader tasks of assessment, support and intervention for at-risk families.

Child Protection should seek written advice and recommendations from professionals who have sound knowledge of the children and their parents. Written advice is strongly preferred, as "stronger" evidence of a carefully considered professional opinion, compared to a chat over the phone.

Current integration of Child Protection with Health services is too limited. Child Protection uses poorly, or fails to use, advice from organizations and individuals out-side the DHS and welfare sector while the Health sector risks being viewed as not part of the overall child protection system. A "silo mentality" within Child Protection impedes good integration of services across sectors.

Some Child Protection workers appear to hold a degree of suspicion about the role of health professionals and of the potential "usefulness" to Child Protection of a child's medical assessment. Perhaps the focus should be on the usefulness in the medium to long term of the medical evaluation to the child, not the immediate usefulness of the medical evaluation and medical report to a child protection worker.

Some VFPMS staff opined that Child Protection workers seem to work in isolation from other agencies. Use of other agencies seems to occur when there is a procedural imperative (for example decisions about whether and when to obtain a forensic medical opinion seem to be driven by a need to satisfy a checklist rather than because there has been an individual case-based evaluation of a child's needs and desired outcomes).

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

VFPMS shares views expressed by others about the Child Protection workforce in that the turnover of Child Protection workers is too high, retention rates are too low, progression to senior management positions is too rapid and many workers are relatively junior and lacking in life experience. These are factors that plague the child protection workforce in many regions of the world; Victoria is no different in this regard.

Measures that improve access to, and the quality of, training and face-to-face support and mentorship are supported.

At times it appears that a decision about whether or not to immediately remove a child from his/her parent's care is made by someone in a distant office who has only limited information about a child's situation. While this contemporaneous support with decision-making resting on more experienced shoulders is certainly valuable, it is not as valuable as on-site team-work with more experienced colleagues. Perhaps joint work with experienced police (one Child Protection worker teamed with one police officer) might prove useful in some situations.

a. Family services

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

Strengths
Sound principle
The focus on better supporting vulnerable adults who are experiencing difficulty meeting parenting responsibilities is sensible.

Weaknesses
Better integration with early childhood services and other CHILD focused interventions is required.
There exists a lack of criteria to determine which cases are better managed by Child Protection and which cases are better managed by Child FIRST. Workloads, regional variations and ad hoc decision-making at worker's discretion seem to determine allocation of cases in and out of the domain of the statutory agency.
Following initial allocation to Child FIRST, Child FIRST may retain case management in spite of escalating and unacceptable risks to the child.
The current practice of allocating serious cases of child neglect to a welfare based intervention by Child FIRST rather than a forensic intervention, requires scrutiny.

Child FIRST practice of dealing with excess demand by "closing books" or having a waiting list is not sensible.

Child Protection seem reluctant to investigate a situation of recognized risk / possible harm when Child FIRST are currently engaged. This undue regard for "turf and territory" once an initial decision has been made, and a reluctance to question or reconsider a decision about risk, can place children in additional jeopardy.

The current trend towards promptly allocating case management responsibility (for some children referred to Child FIRST) to NGOs seems to lack accountability and transparency. Whilst this action (transfer of case management) lessens the number of children for whom Child FIRST maintains engagement, the focus can shift from the child to the adult carer without adequate regard for the child's needs.

Governance and transparency of decision-making and service delivery varies between NGOs. Matters related to accountability require further consideration.

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

Child Neglect is a potentially fatal condition. Increasingly, it appears that reports to Child Protection are being delegated to Child FIRST to provide a welfare based approach to intervention. A comprehensive forensic evaluation of neglect is rarely undertaken (by Child Protection) as evidenced by the decreasing incidence of substantiated neglect (AIHW). Victoria's rate of substantiated neglect (2009) is less than half that of the next nearest state and one third to one fifth the substantiation rate in other states.

Child FIRST is NOT a suitable agency to evaluate serious child neglect. Alleged child neglect should elicit a multidisciplinary investigation by police, health and child protection professionals.

The NSW focus on more active intervention in cases of serious neglect (consideration is given to the criminal aspects of serious neglect) may be worth emulating.

Better use of police and forensic health experts to evaluate serious situations of child neglect (including situations of medical neglect) should be considered

The diversity of NGOs providing services to better support parents warrants evaluation. In general, the effectiveness of programs to support neglectful parents should be evaluated.

b. Statutory child protection services, including reporting, assessment, investigation procedures and responses;

3.4 What are the strengths and weaknesses of our current statutory child protection services in relation to responding to and assessing suspected child maltreatment?

The practice of interviewing children about possible abuse in the absence of parental knowledge or consent is concerning. Consideration should be given to the potential for Child Protection and police to cause psychological harm to children by this practice. The child's right to access a support person of their choosing prior to interview should also be respected as should the child's right to be informed about the potential outcomes of questioning. Particular concern is expressed about the practice of removing children from their classes for interview with police and Child Protection workers.

Initial response and assessment can include a forensic medical evaluation by VFPMS. In relation to these referrals VFPMS makes the following observations:

- A higher quality medical assessment may occur when the accompanying worker knows the child and the case (the story of the child's situation)
- Children are usually better prepared and emotionally supported when they are accompanied by a familiar adult. An adult who has a good knowledge of the child's development and health is especially valued.
- When only a small amount of information is shared by Child Protection, the quality of the VFPMS evaluation suffers. With-holding of information from VFPMS can seriously reduce the validity of the forensic opinion provided.
- The practice of workers repeatedly telephoning a senior worker for advice can create the impression that the worker might lack the skills and capacity to make decisions. It is particularly dispiriting when initial case-management decisions are reversed for elusive reasons. Angst can be experienced when, for pragmatic reasons such as a lack of available alternative care placements, a decision is made for a child to remain in a high-risk situation, particularly when there is a difference of opinion between the health professional and the Child Protection worker. An appeals process for professionals in relation Child Protection case-based decision-making would be greatly valued.
- Recommendations provided by VFPMS are made with the child's future health and developmental needs in mind. These recommendations should be carefully considered and, if not implemented, reasons should be provided by Child Protection for this decision.

The impression exists that relatively few cases of serious neglect are substantiated and few cases of serious neglect achieve outcomes in the Children's Court that result in children being placed on orders. The structure that "steers" cases of neglect towards a welfare based Child FIRST intervention appears to result in low level parent-support based interventions with the result that very needy children remain in dangerous situations.

There is a difference between "at-risk" and neglect. Neglect of infants and seriously harmful, multi-faceted, longstanding neglect should be investigated by Child Protection.

3.4.1 How might the identified weaknesses be best addressed? If there are places where some statutory child protection services work more effectively that elsewhere, what appear to be the conditions associated with this and how might these conditions be replicated elsewhere in the State?

Workers and case managers should be encouraged to seek advice from professionals in health and mental health in relation to case-planning. Current impediments to sharing information between Child Protection and health should be reviewed. (privacy issues are poorly understood and should not prevent appropriate access to information and advice relevant to the child's health and welfare)

Retaining existing staff is cheaper than recruiting and educating a continuous stream of new inductees. Consideration could be given to reward programs (recognizing good practice) scheduling regular periods away from the front line, and a professional development program that, from the outset, requires a commitment to ongoing study.

Morale is often low. Under perceived pressure from a critical media and general public, a siege mentality can result in bunkering down and defensive posturing by CP workers. This can restrict transparency and crush CP workers (and managers') desire to address deficiencies in the system. A health approach to "peer review" and "quality assurance" is worth emulating

3.4.2 Is the overall structure of statutory child protection services appropriate for the role they are designed to perform? If not, what changes should be considered?

The lack of timely high-quality legal advice is a serious handicap to CP workers. Money spent on the army of front line workers might be better spent on a few wise generals with high level understanding of the options for intervention – legal and otherwise.

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

Major increase in case numbers entering the system (which was not prepared for such numbers). A system of categorizing priority for response is still required.

Unintended consequences

- An over emphasis on the relatively minor end of the scale eg minimal physical injury inflicted in the setting of physical discipline resulting in the mobilization of 2 protective workers, 2 police officers, case conferences, medical assessments, court.
- An inconsistent approach to involvement with Children's Court and an extremely inconsistent approach by police to charging parents who inflict physical harm on children
- Reluctance to intervene in ways that aim to improve parenting practices and reduce children's behavioural problems (ie aim to improve parent-child relationships and interactions)

A system for reporting that lacks capacity to effectively manage the caseload is unlikely to work effectively. There is a risk that relatively "low thresh-hold" cases will clog up the system while serious cases are missed or responses are too slow.

An inefficient, ineffective statutory agency response dissuades notifiers from reporting, despite mandatory reporting requirements. When it is difficult to access statutory agencies then notifiers feel tempted to give up and there is a risk that notification will not occur. Access to Child Protection via fax, email or on-line notification forms would be appreciated.

A lack of demonstrable action on the part of Child Protection, a lack of perceived benefit following notification and/or a perception that harm has occurred as a result of notification, can result in a sense that reporting is "futile". Feedback from Child Protection to notifiers is essential.

c. Out-of-home care, including permanency planning and transitions

3.5 What are the strengths and weaknesses of the range of our current out-of-home care services (including respite foster care, foster care of varying durations, kinship care, permanent care and residential care), as well as the supports offered to children and young people leaving care?

Weakness: kinship placements are inadequately supported
Two standards of governance and support exist. Kinship carers are under less scrutiny, are less accountable, are poorly financially supported and children frequently receive less intervention overall than children in non-kinship out-of-home-care placements.

Every effort should be made to avoid a child transitioning through multiple changes in placement.

Suggestion
A comprehensive, well-documented child health record for children in out of home care
Greater sharing of knowledge about children in out of home care (particularly in relation to past medical /developmental history and family history) could

significantly improve health care for children in out of home care. When health professionals are better informed about a child's health, growth, development and behaviour, the health professional is in a much improved position to provide quality health care for the child. Lack of information about some children continues limit their access to appropriate health care. (Hep C status, exposure to in-utero drugs and toxins, family history of inheritable medical illness are a few examples)
A tokenistic child health record would be insufficient; the quality of information contained within the record determines its benefit.

Residential care facilities in Victoria require evaluation. Significant problems exist in relation to supervision (or lack thereof) of the children. Accountability of the services for the quality of care provided seems poor. Concerns are raised in relation to the lack of psychological and moral guidance for children in this form of out of home care, lack of safety and the lack of constraints on residents' antisocial behavior. Co-location of residents with serious behavioural problems can result in episodes of additional abuse for some residents.

Some residential units are environments conducive to the development of criminal behaviour. A tolerance of drug-taking, truancy, pro-criminal and antisocial behavior seems to foster delinquency. The oversight and management of residential units requires urgent review.

4. The **interaction of departments and agencies, the courts and service providers** and how they can better work together to support at-risk families and children.

4.1 Given the very broad range of professions, services and sectors which need to collaborate to achieve the best outcomes for vulnerable children:

4.1.1 Are current protocols and arrangements for inter-organisational collaboration in relation to at-risk children and families adequate, and how is the implementation of such protocols and arrangements best evaluated?

If the outcome for the child is poor, consideration as to the arrangements for interagency collaboration is moot. Evaluation should focus on outcomes for the child.

Health professionals, particularly forensic health professionals, have a key role investigating cause of injury. A tripartite approach to the evaluation of neglect and abuse should be encouraged. (Child Protection, Police and Health)

MoU or protocols could be implemented between Police, VFPMS and Child Protection. A more broad based Interagency Agreement could have merit. See 4.1.4.

Police should continue to have a lead role in investigating situations of serious assault.

SCAN (Suspected Child Abuse and Neglect) multiagency professionals case conferences should occur within 24 hours of admission for each child hospitalized because of suspected neglect or abuse (as is current practice at the Royal Children's Hospital)

A 12 month evaluation of the outcomes of these SCAN meetings (with a focus on multiagency decisions about diagnosis, diagnostic certainty, planned actions and interventions) would be informative.

4.1.2 What needs to be done to improve the quality of collaboration at the levels of policy development and implementation, local and regional service planning and delivery, and direct service to individual children and families?

Policy:
Use of advice regarding policy from beyond the Child Protection sector (with additional across-sector advice provided via annual strategic planning meetings) In particular, advice from representatives from health, housing and DEECD sectors should be sought and used.

Whole of government approach (UK model) is supported

Direct service level:
Given the severity of family dysfunction and the high incidence of mental health disorders affecting both vulnerable children and their families, there is often a need for leadership in case management by Child and Adolescent Mental Health Services (CAMHS). CAMHS capacity to respond has, at times, been limited due to overwhelming demand for their service. This has left Child Protection workers without advice and guidance from experienced mental health workers with the result that vulnerable children are further disadvantaged. Formal agreements between CAMHS and Child Protection might determine criteria for CAMHS engagement and the nature of the collaborations between both professional groups.

Note that the Take Two service is not a "CAMHS-alternative". The inquiry panel is encouraged to explore how CAMHS and Take Two services might work more collaboratively.

4.1.3 Are there specific models of inter-professional, inter-organisational and/or inter-sectoral collaboration which have been shown to be effective or promising, and which may be worthy of replication? This may relate to two organisations (for example, child abuse issues in which both police and statutory child protection services need to collaborate in an investigation) or to a much broader service network.

SCAN meetings (Police, Child Protection and Health professionals) case conferences. This model of early case conferencing has been operational at the Royal Children's Hospital for more than a decade. VFPMS strongly supports this approach.

Pre Children's Court joint case planning – Child Protection and Health professionals

An evaluation of the frequency with which medical evaluation of injury/risk of harm and health professionals' recommendations are adducted as evidence in Children's Court might result in improved practice for both professional groups.

4.1.4 How might professional education prepare service providers to work together more effectively across professional and organisational boundaries?

Development and implementation of an Interagency Agreement:
MoU between Child Protection. Health, Police and Children's Court
A document that "spells out" the framework (principles underpinning practice and the desired outcomes of good interagency collaboration) in which the professional groups interact.
It could contain

- clear definitions (written/ accessible to all) of professionals' roles and responsibilities
- codes of conduct
- processes for communication and collaboration
- dispute resolution process

Education
Pool Police/Child Protection and Health resources to produce a single group of modules for cross disciplinary education
Share educational opportunities (invite a broad range of professionals to education and training that might be appropriate
Encourage multidisciplinary attendance at seminars and workshops
Web-based interactive educational modules to provide the same educational material to several disciplines

Communication
Greater ease of access and better processes for communicating information to Child Protection would lessen Health professionals' frustrations.
Consideration should be given to email communications (perhaps restricted to use by doctors and police) or notifications to Child Protection using on-line forms.

5. The **appropriate roles and responsibilities of government and non-government organisations** in relation to Victoria's child protection policy and systems.

Within defined parameters and subject to contracts and accountability, NGOs provide some parent support / interventions
Only for children, and parents of children, at low level risk

5.1.2 What roles currently performed by statutory organisations, if any, might be more effectively and efficiently performed by non-government organisations, and vice versa?

Caution should be exercised. A transfer of case responsibility should be considered for low risk situations only.
Parameters should be clearly defined with regards to determining when (under what circumstances) NGOs should re-engage statutory agencies.

Whilst it is tempting to consider how best to harness the efforts of a large, well motivated but variably well-trained and relatively unregulated NGO workforce, there exists a need to carefully monitor decision-making and to provide accountability.

5.1.3 What is the potential for non-government service providers to deal with some situations currently being notified to the statutory child protection service, and would it be appropriate (as is the case in Tasmania) for referrals to a service such as ChildFIRST to fulfill the legal responsibilities of mandated notifiers?

It is not appropriate for NGOs to deal with notifications to statutory agencies. Matters of responsibility / legislation / accountability and NGOs capacity to deal with error and poor practice need to be considered.

Notification to Child FIRST could fulfill legal requirements of mandated notifiers if (and only if) clear criteria are implemented to determining (as much as is possible) allocation of cases to Child Protection or Child FIRST.

6. Possible **changes to the processes of the courts** referencing the recent work of and options put forward by the Victorian Law Reform Commission.

Suggestions

1. Research: Feedback from Child Protection to the Children's Court regarding 12 month outcomes of decisions/dispositions in the Children's Court

2. Children's Court magistrates (and others) to seek advice from services such as VFPMS regarding the need for, and potential utility of, medical evaluation before "ordering" it.

3. Children's Court magistrates should not delegate decision-making regarding protection issues to Children's Court Clinic professionals (particularly when the opinion of the Children's Court Clinic Psychologist is not subject to cross examination or appraisal by other professionals)

4. Children's Court magistrates should access training from services such as VFPMS on specialist topics.

5. All relevant forensic medical reports should be submitted to the court, not selectively with held by Child Protection or counsel. Forensic medical reports should be produced "in toto" for the courts consideration, never in part or as "selective quotes" that might be misinterpreted or misused.

6. Reports from Children's Court Clinic assessments should be subject to scrutiny and cross examination in the same manner as other professionals' reports. The Children's Court Clinic should not be used by Children's Court magistrate's to "quasi delegate" decision-making in relation to protection matters.

There has been very little research into the operation and outcomes of the Children's Court. This is an area of critical importance
Further research should be a HIGH priority
Evidence should inform decisions about the desired / most effective structure and function of the Children's Court.

In the absence of evidence there is an ongoing risk that decisions around planning for the future will continue to be driven by political whim and pressure from lobby groups.

The potential benefits of a less adversarial court system are recognized and supported. Family case conferencing and shared decision-making about a child's residency and ongoing care is also supported. An approach that encourages voluntary changes on the part of the caregiver to improve the safety and quality of the child's life are to be encouraged.

However, the inherently adversarial nature of intervention by the state to remove children from their parents' care or to exert some control over parental decision-making cannot always be avoided. When the state seeks to infringe on a parent's right to provide day-to-day care for his/her child, it is in the interests of justice for the matter to be adjudicated by the courts and for the parent to have access to legal advice and support to assist them in

mounting a challenge to Child Protection's application, should they wish to do so.

8. The **oversight and transparency** of the child protection, care and support system and whether changes are necessary in oversight, transparency, and/or regulation to achieve an increase in public confidence and improved outcomes for children.

8.1 There is currently a range of oversight processes involved in the child protection and care system (for example, inisterial/Departmental inquiries into child deaths and serious injuries, internal organisational complaints procedures, and the statutory roles of the Ombudsman, the Victorian Auditor General, the Child Safety Commissioner and the Coroner).

8.1.1 Are these processes appropriate or sufficient?

These processes are sufficient for the tasks of discovery and recommending solutions. They are an insufficient strategy for resolving problems. They are rarely reparative.

The role of the Child Safety Commissioner could be increased to provide greater oversight of the operation of Child Protection and Child FIRST. Restructuring of the Office of the Child Safety Commissioner to include a broader role as Ombudsman for protecting children – ie greater scope to investigate matters related to actions by police, education and health professionals - and responsibility to a minister other than the minister for DHS might provide greater accountability.

8.1.2 What exists in other jurisdictions which may be worth considering?

NSW style Child Death Inquiry.
Note the different terms of reference for NSW panel compared to the VCDRC (which has a narrower range of child deaths to review and an enquiry process and reporting structure contained within the DHS child protection system)

8.1.3 What changes, if any, are required to improve oversight and transparency
of the child protection, care and support system? How would those changes contribute to improved outcomes for children?

A multi-sectorial advisory committee could meet quarterly to offer advice to Child Protection in relation to policy and operation of the Child Protection system
Membership to include Children's Court, legal representatives (experts in Law Reform), police, health representatives including both forensic health

(VFPMS), mental health (CAMHS) and forensic pathology (VIFM re fatal abuse) as well as NGOs, foster- parents and social workers.

8.1.4 Are there strategies which might increase public understanding of, confidence in, and support for child welfare services?

An adversarial approach from senior bureaucrats and ministers to critical media comment serves to further demoralize the workforce and generate an image of a public service department under siege. A defensive "we know best" stance from Child Protection in response to challenges and criticisms from politicians, the media, the public and NGOs inhibits a focus on finding solutions.

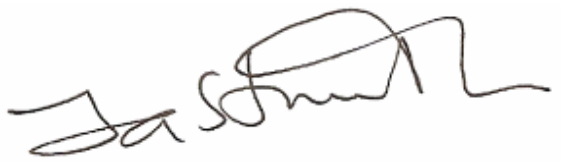
Suggestions
Significant "culture change" within Child Protection to a more transparent, less defensive response to criticism is required.

A "root cause analysis" approach to investigating complaints is encouraged.

Independent review, rather than internal investigations, should be encouraged.

The Victorian Forensic Paediatric Medical Service thank the panel of Inquiry into Protecting Victoria's Vulnerable Children for reading this submission. We hope that some of our observations and opinions might prove constructive.

Yours sincerely



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