WESTERN INTEGRATED FAMILY VIOLENCE PARTNERSHIP (for women and children)

RESPONSE TO

PROTECTION VICTORIA'S VULNERABLE CHILDREN INQUIRY

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Vulnerable Children Inquiry

Western Integrated Family Violence Partnership (for women and children) (WIFVP) welcomes this opportunity to comment on Victoria's child protection system and make recommendations to support vulnerable children. We believe this is a positive step toward improving Victoria's child protection system.

About Western Integrated Family Violence Partnership (for women and children)

The Integrated Family Violence Services System (IFVSS) is part of the Victorian State Government's strategy to reduce the incidence of family violence, the leading contributor to death, disability and illness for women aged 15-44 in Victoria.

The primary aim of the Victorian family violence reform was to introduce an integrated service response across community services - including community health, family violence services, police and courts - that improve the safety of women and children and to hold violent men accountable for their actions.

Since July 2006 women and children affected by family violence in the Western Metropolitan sub-region have been supported by a consortium of local agencies including Women's Health West, Western Region Health Centre and MacKillop Family Services. In 2010, Molly's House and McAuley Community Services for Women joined the partnership. This integrated multi-agency approach provides a range of support services, counselling and group work programs. Better communication between agencies will ensure that women receive an appropriate, gendered response, regardless of the pathway by which they receive assistance.

Like many other specialist family violence services we have a special interest in ensuring that children experiencing family violence are adequately protected in the child protection process. Many women and children accessing our services experience disadvantage such as women from cultural and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander women, women with disabilities and women from rural and remote communities and it is our aim that they do not experience further disadvantage through child protection processes.

The more informed the Government is about the strengths and limitations of the current child protective system the easier it will be to respond to the community expectations about the response to, and prevention of, child abuse and neglect.

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

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

The relationship between child abuse and family violence needs to be emphasised. A growing body of research in Australia and overseas recognises that family violence and child abuse frequently occur within the same families.[1] The prevalence of family violence in our community is well documented with one in four Victorian women having experienced intimate partner violence. Consequently it is unsurprising that one in four Victorian children have witnessed family violence.

In 2005-06 family violence was identified as a risk factor in 53 percent of the substantiated Victorian child protection cases in non-Aboriginal families and in 64 percent of Aboriginal families.

It is critical that the Victorian Government commit to a family violence prevention strategy that simultaneously tackles violence against women in the community and minimises the impact on children as both victims of the violence and witnesses to it.

The Western Integrated Family Violence Partnership encourage the Victorian Government to endorse VicHealth's 2009 plan, 'Preventing violence against women: A framework for action'. We also urge the government to use the social and economic determinants of health to develop a state plan to prevent child abuse and neglect.

The engagement of Victorian local governments and community leaders is vital to the development of community and population-based prevention strategies. In August 2010, local government and community leaders came together to showcase community-based prevention of violence against women strategies. The western metropolitan region was well represented, with local councils and Women's Health West providing nine of the thirty-five examples.

'Preventing Violence Together: Western Region Action Plan to Prevent Violence Against Women' is an example of a collaborative regional partnership bringing together local government and community organisations to develop a community-based prevention strategy. Government support of such initiatives is important not only to drive community involvement in preventing violence against women but also to highlight the impact of family violence on their children.

The most cost effective strategy to reduce the incidence of child abuse will be one that is well researched, consulted and planned. The current child protection system fails to consult with the community or integrate with key services. Child protection services should not operate in a vacuum and must

1 Family Violence Services, Child First/Family Services, Child Protection State-wide Partnership Agreement, 2010

respect community expectations. The Victorian community is concerned about children; this is most evident when the community responds in shock when children are killed by adults. It is unnecessary for us to retell these stories of the children we have failed to protect.

An effective community awareness campaign would not sensationalise the abuse of children in the manner of tabloid media, but would be sensitive to those that need information and education and to encourage victim disclosure.

Any child abuse and neglect prevention strategy should focus on parents and their children. A good strategy recognises that — other than in extreme cases of child abuse, neglect and sexual abuse — it is better for children to remain with their biological parents. Preventing child abuse and neglect begins with supporting and educating these parents. Accordingly, adult-focused family violence services take on the responsibility to educate women and men on the impact of family violence on children. For example, Women's Health West provides an information package for parents titled 'Choosing Positive Paths: a resource and information kit for parents concerned about their children'.[2] Women who have experienced family violence often need to manage their own recovery, their children's recovery and in many cases rebuild the mother-child relationship that has either been sabotaged by the perpetrator or damaged by her unavailability during the abuse.[3]

2 You can download the kit from http://www.whwest.org.au/info/pkindex.php

3 Cathy Humphrey's & Nicky Stanley (2006*) Domestic Violence and Child Protection: Directions for Good Practice,* Jessica Kingsley Publishers, London.

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

Higher Order Priorities

Strategy	Timeline	Actions
1. Build on current family violence prevention strategies	Immediate (1 year)	1. Endorse Vic Health Preventing Violence Against Women Strategy 2. Develop Victorian Government Preventing Violence Against Women Plan that builds on what had been developed by the previous Governement. 3. Support and encourage the development of Regional, Local Government and Community Violence Against Women Prevention Plans
2. Develop strategic framework for the prevention of child abuse and neglect	Medium (2-3 years)	1. Based on whole-government approach 2. Stakeholders include Government, Non Government and the wider Community 3. Key Settings • Local Government • Health and Community Services • Child Care and Education • Sports and Recreation • Media, Art and Popular Culture
3. Develop and implement child abuse and neglect prevention plan framework	Medium (2-3 years)	1. Develop a model of the social and economic determinants of child abuse and neglect.

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

The most cost effective strategy to reduce the incidence of child abuse will be one that is well-researched, consulted and planned.

The most cost effective way to reduce child abuse and neglect is to target at-risk communities or populations identified in the Child Abuse and Neglect Prevention Plan Framework. These strategies should be specifically designed to meet the needs of the target group, for example the needs of the Aboriginal community will be different to those of refugees and newly-arrived communities.

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

The intersection between family violence services and child protection is well documented. Edleson (2001) reviewed 36 studies indicating that between 30-60 percent of children whose mothers were being abused were likely to be victims of abuse.[4] There are examples where both family violence services and child protection have successfully worked together to improve the outcomes of children. Historically, examples of collaborative practice have been few in number and inconsistent in their application; often overly dependent upon individual worker relationships and networks.

In 2010 family violence services, child protection and Child FIRST/family support agencies came together to develop a partnership agreement in recognition that to meet the needs of vulnerable children and young people we must implement a multi-agency approach and work together toward better prevention and early intervention.

These regional partnership agreements are in their infancy, however early indicators show they are an effective tool for change. In the western region of Melbourne a 'Think Child' working group implements the agreement. Membership includes North West Metropolitan Region Child Protection, family support agencies, Child FIRST, Department of Human Services, Victoria Police and both men's, and women and children's family violence services. At present the group is exploring the entry and referral pathways to the different service systems and assessing ways to better coordinate a multi-agency response.

CASE STUDY

Client is an 11 year old female who was referred by Centacare family support worker to Women's Health West. She had witnessed years of both emotional and physical violence against her mother perpetrated by her father. The family court has ordered for the client to visit her father every second weekend and Wednesday night. The client was subject to physical violence by her father. The client also reported emotional abuse during access visits.

She was the victim of bullying incidents and was aggressive to other children at school and at home after returning from access visits. This resulted in the client running away when she was waiting for her father to pick her up from school.

This child had previously been known to Child Protection through the reports by agencies such as the school, Centacare, Police and Child First but Child Protection had been unable to act due to a lack of evidence. According to the mother she had sought help from Child Protection but was informed that she may be charged due to the number of notifications she had made.

On the third session, the client expressed anxiety about the upcoming access visit with the father. She revealed to the Counsellor that she was scared and did not want to go with him. She reported that she had been hit by her father for not wanting to play with her step sibling and this was witnessed by her younger brother. She remembered that the he had hit her quite hard (6 or 7 on a scale of 1 – 10, with 1 being a tap) but was unable to provide further details of this event. She also reported being dragged to the car which resulted in bruising.

The worker phoned Child Protection and was informed that there was a community based worker for the family to contact. Women's Health West (WHW) worker contacted the community based Child Protection worker who said that she was not the right person to be taking the new notification as the case was closed. The worker was advised to therefore go through the intake system for Child Protection. Worker then called Child Protection intake worker and told them the name of the child and that she had been hit by her father and was informed that they were unable to take a notification at this time of the day (4.57pm after a long wait on the phone) and suggested for worker to contact after hours service or call back the following day. He also suggested that the WHW worker should contact a family support worker at Centacare who was the original referrer for the client to WHW. WHW worker was unable to make contact with the community based Child Protection worker and she left a message as situation was not urgent. A case conference was initiated by WHW worker due to the difficulty of notifying Child Protection, inviting all relevant agencies to provide strategies for further assistance to this client and family.

4 Graham-Bermann SA and Edleson JF (2001) *Domestic Violence in the Lives of Children: The future of Research, Intervention and Social Policy*, American Psychological Association, Washington. pg. 91

In September 2008, the Western Metropolitan Region introduced a pilot Integrated Family Violence High Risk Client Strategy. The strategy brought together Victoria Police, women and children's services (Women's Health West) and men's behavioural change program providers (LifeWorks, Relationship Australia and Djerriwarrah Health Service) together to respond to clients who are identified to be at immediate risk of extreme violence or death. Over the past 2 years more than 20 women have been notified as a high risk client and a high risk case conference convened to implement and undertake a shared safety management plan. The benefits of a high risk strategy include:

- Improved safety of victims and their clients
- Client focused, tailored service delivery
- Reduce family violence recidivism
- Sharing in formation
- Improved understanding of abilities, limitations and constrainst of agencies
- Decrease costs
- Reduce police man hours expended responding to family violence

The reference group has identified that the inclusion of a child protection representative onto the group as an immediate priority.

2.2 How might the capacity of these services and the capacity of organisations providing these services be enhanced to fulfil this role?

Family violence services, especially those targeted at children, are underfunded and overwhelmed due to the level of demand for specialist family violence counselling and support. Women's Health West employs two part time children's counsellors who cover the whole western metropolitan area of Melbourne. Nearly 25 percent of their current referrals are from child protection or have been recently involved with the child protective system. In 2009-10, we provided 73 children with individual counselling and a further 12 children attended our therapeutic group. Victoria Police data shows that 2,795 children living in the western region were present at a family violence incident in 2007-08. The number of children who have witnessed family violence and received no specialist support is staggering. The Western Integrated Family Violence Partnership (for Women and Children) calls for immediate funding of a minimum of four additional children's counsellors and at least one specialist adolescent counsellor. It would cost the government approximately $5 million to implement this state-wide.

These additional family violence children's counselling positions would increase the capacity of family violence agencies to work collaboratively with child protection services and, in the case of some children and their families, reduce the demand for protective services.

The introduction of adequate children's counselling services is an early intervention strategy that doubles as a prevention strategy since victims of

child abuse and witnesses of family violence are at increased risk of being victims or perpetrators of abuse and violence as adults. [5]

In addition, we call on the government to fund additional positions within family violence outreach case management services to build the capacity of family violence outreach services to respond to children. In 2009-10, Women's Health West family violence outreach services provided case management support to 375 women and approximately 65 percent of these women were accompanied by children (1,325 children).[6] The outreach service does not have a specialist children's worker. Generalist workers do their best to ensure that risk assessments are carried out for children and, where possible, link them to appropriate support services. This may involve explaining the child's situation to the school and discussing possible supports they could provide including access to school counsellors. However, this solution is inadequate for children exposed to extreme and/or long term family violence and those who show symptoms of trauma and Post Traumatic Stress Disorder (PTSD).

Approximately 20 percent of children exposed to family violence develop symptoms of PTSD lasting more than twelve months.[7] This means that too many children and their mothers are left alone to recover from the trauma of family violence.

We must address the trauma experienced by children. We argue that the 'dysregulated behaviours of children exposed to violence, their difficulties with cognitive functioning, and their fears may be accounted for in part by their natural reaction to the trauma'.[8] These symptoms have often been miscategorised as 'behavioural problems'. This is because many of the symptoms of PSTD — like aggressiveness, irritability, high arousal, anxiety, and lack of social engagement — are also measured by the Child Behaviour Checklist used by psychologists to measure externalising and internalising behaviour problems. If left untreated, children can carry their trauma symptoms into longer term behavioural problems.

As a result, we strongly suggest that these children's problems are treated with trauma interventions and if certain forms of behaviour persist (e.g. conduct disorder, depression or anxiety) then more traditional interventions could be considered.

Implementation of such a model would require two simultaneous actions:

1. Train child protection, Child FIRST and family support services to assess children for trauma. Practitioners using this approach should first view children's behaviour from the child's perspective, as a

5 Kalmuss, N.D. (1984) The Intergenerational Transmission of Marital Aggression, Journal of Marriage and Family 46, 11-19

6 Women's Health West Annual Report 2009-2010

7 Devoe E & Graham-Bermann S (1997) Predictors of post traumatic stress symptoms in battered women and their children. cited in Graham-Bermann SA and Edleson JL (2001) Domestic Violence in the Lives of Children: The future of research, intervention and social policy. American Psychological Association, Washington.

8 Ibid. pg. 37

'natural reaction to trauma' rather than as a 'behavioural problem', which has a tendency to assign blame to the child or the parent as evidence of 'bad parenting'.

2. Build the capacity of the funded child-specific support system to focus on childhood trauma. Child-specific services must complement family support services, family violence services and other adult-focused services. In critical areas these programs and services should be delivered side-by-side and provide trauma interventions such as therapeutic individual, family counselling and group work. Current best practice examples we can build on include: Royal Children's Hospital - Peek a Boo and PARKAS groups, Women's Health West therapeutic children's counselling program (individual and group work), and family services - Take Two Program.

It is critical that family violence services are adequately resourced to support children and young people who are victims and witnesses to family violence; not only to support children to recover from the trauma but also to ensure that children are diverted from the child protection system.

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

Higher Order Priorities

Strategy	Timeline	Actions
1. Increase the capacity of Child FIRST to respond to family violence	2011-12	1. Pilot placement of FV Outreach Worker within Child FIRST 2. Women's Health West and Brimbank / Melton Child FIRST to proceed with pilot. 3. Women's Health West to provide a worker one day a week. 4. Apply to the Western Region Integrated Family Violence Committee for funds to evaluate pilot. 5. The pilot is extended to other regions across the state.
2. Increase the participation of Child Protection in Integrated Family Violence	2011-12	1.Child Protection Representative join the Western Metro High Risk Strategy
3. Integrate children's family violence outreach worker into family violence outreach	Immediate budget 2012-13	1. Position located in family violence outreach services to: • Undertake child/ren assessment, • Liaise with child protection, Child FIRST and family support agencies • Advocate needs of the child • Deliver community education explaining the impact of family

		violence on children
4. Build the capacity of family violence services to respond to children	Medium to Long Term (Over 4 year) Budget 2012-17	1. Build the funding of family violence children counselling programs over 4 years to focus on trauma and attachment - individual, sibling group and primary care giver and child counselling and group work. 2. Ensure metropolitan regions or subregion have an additional 4 children's and 1 adolescent counsellor by 2017. West, North, East, Inner South East and Outer South East. 3. Fund rural regions for additional 2 children and one adolescent by 2014. Barwon, Grampians, Loddon Mallee, Hume and Gippsland 4. Set funding at $95,000 per EFT. 5. Allocate approximately $4,275,000.00 total recurrent funding per year to ensure services are fully funded.

3.1 Over recent years Victoria has been developing an increasing 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 weaknesses be addressed?

There is clear evidence that integration and multi-agency service responses facilitate and enhance the capacity of system response and improve client outcomes. It made sense that initial child protection reforms were restricted to those services that had historically worked with child protection. The integration initially consisted of child protection and family services through Child FIRST. It also made sense that the integrated family violence reforms initially involved magistrates' court, police and specialist family violence services. We know that child abuse and family violence co-occur and that the two integrated service responses intersect. However, this intersection has been happening at an individual client level rather that at a systems level.

As mentioned previously, the Think Child Agreement is working to better link child protection, Child FIRST, family support services and family violence services. The Western Metropolitan Region Think Child Working Group will be piloting the introduction of a specialist family violence worker within Brimbank/Melton Child FIRST at MacKillop Family Support Services located in Melton. A Women's Health West family violence outreach worker will be place-based at Child FIRST one day a week and will provide secondary consultation support. Women's Health West has agreed to fund the placement for 6 months of the pilot. We hope this pilot will demonstrate an example multi-agency collaboration that improves outcomes for clients.

Developing, implementing and monitoring integrated and multiple service responses is resource intensive. Mechanisms are required to support integration including:

- Specialist coordination/project positions e.g. regional integration coordinator (Integrated Family Violence)
- Regional partnerships and committees e.g. Brimbank Melton Integrated Family Services, Western Regional Integrated Family Violence Committee
- Regional working groups, network meetings and committees e.g. Think Child Working Group, Wyndham Family Violence Committee

These mechanisms are critical but time and resource intensive and generally it is the good will and commitment of individual agencies that ensures these integration systems work. Relationship building and maintenance across programs, agencies, and sectors is generally left to the community sector agencies; a task that can be quite difficult when managing competing demands placed on organisations.

In addition, workers state that prior to the introduction of new child protection legislation and the development of Child FIRST there was open dialogue between workers in an advisory capacity. Now, child protection intake or individual workers consider all communication from workers to be a notification. We recommend that family violence services be given access to Child FIRST community child protection workers so that consultation can occur without that consultation being considered a notification. We

understand that this will require change in legislation however this would also highlight the importance of the relationship between family violence and child protection service systems.

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

In a statutory area, such as child protection, it is particularly important that staff are adequately trained, remunerated and experienced. The work is difficult, complex and demanding and as such the inquiry should focus on workforce capacity as a key area. Any further increase in workloads or expectations without improving existing circumstances will merely aggravate the present situation of inexperienced staff and low retention rates.

Further specialisation of child protection to only respond to those children at immediate and extreme risk will compound the occupational health and safety risks faced by the workforce such as vicarious trauma, stress, anxiety and depression. The trend of past decade has increasingly restricted Child Protection Service staff to dealing with those in the gravest danger with little or no capacity to provide early intervention services to at risk children. The ability to provide a mix of service responses from early intervention to crisis to long term would create a balanced work load and thus reduce workforce fatigue.

Role diversity and risk management
Further specialisation would create a workforce constantly dealing with vicarious trauma and is not recommended due to the negative impact on staff.

We recommend Child Protection Service staff spend more time at other agencies, thereby gaining better understanding of the wider community service system and expanding their own experience and expertise. A secondary benefit would be that community agencies would also develop a better understanding child protection and ‘best interest’ child principles. Ultimately, as child protection becomes more involves with — and better skilled at — working with others, multi-agency work should become second nature.

Child protection staff must develop a better understanding and knowledge of family violence not only from the child’s perspective but also that of the adult victims. ‘Family violence has a major impact on the health and wellbeing of children. Recent meta-analyses have shown that children exposed to domestic violence exhibit significantly more problems than children not so exposed. Children are regularly exposed to the damaging effects of family

violence both as witnesses of violence against mothers and direct victims of assault and emotional abuse.'[9]

Family violence and trauma-specific training would enhance the ability of child protection staff to work within, and understand, the impact of violence and trauma on children and women.

a) Family Services

We propose that the recommendations of the KPMG Child FIRST and Integrated Family Services Interim Report (2009) be reviewed as the key finding are relevant today including:

1. 'Further work is also needed in engaging universal and secondary services in the Alliances. In some cases, previously effective relationships have suffered due to a focus on establishing Child FIRST and Integrated Family Services, and these need to be reactivated to enable a more strategic approach to catchment planning.'[10]

The WIFV Partnership consulted with family violence staff in the development of this submission. Staff stated that the Child FIRST reforms had a negative impact on their relationships and networks with family support services. Communication between workers was fluid prior to the introduction of these reforms. Workers were able to build beneficial relationships with family support workers where both called each other seeking information and advice. Now workers referred to Child FIRST intake are unable to provide informal 'advice' and information due to Legislative constraints. In addition, workers stated that it was increasingly difficult to refer to family support services because of the domination of child protection referrals to these services.

This encourages workers to notify child protection in order to access family support services rather than because the family requires child protection intervention. While this practice is not common it does highlight the extremes that workers are forced to use because of limited resources. If the Government's intention is to build the capacity of adult-focused services to respond to vulnerable children, it is critical that family support services are resourced appropriately to meet the demand.

2. 'To further support the evolving focus on earlier intervention, there is the need to consider sustainable strategies to address the requirement for more skilled staff within Family Services.'[11]

Early intervention is an important function of Child FIRST and family services, however the capacity of family services to provide this function is being eroded as a result of demand for services. This is especially true for services located in the growth corridors of western metropolitan Melbourne, namely

9 Edleson (2006) cited in Family Violence Services, Child First/Family Services, Child Protection State-wide Partnership Agreement, 2010 pg 4

10 KPMG (2009) *Child FIRST & Integrated Family Services Interim Report 1*, Department Human Services Victoria

11 Family Violence Services, Child First/Family Services, Child Protection State-wide Partnership Agreement, 2010

Melton and Werribee. These services are forced to implement demand management strategies that must prioritise the needs of those children and families who are most vulnerable and complex. Unfortunately, the nature of this demand management only ensures increasing demand over time as families struggle, become more vulnerable and their needs become more complex.

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

Research has challenged child protection agencies in the United States to address the dual problem of under-reporting and over-reporting of child abuse and neglect.[12] It is argued that many children experiencing violence are unreported either because they are afraid to come forward or they are overlooked by professionals. At the same time, a large proportion of reports are unsubstantiated (dismissed after investigation). Victorian Child Protection data suggests that the situation in Victoria is similar. According to 2006-07[13] data there were 38,432 notifications to child protection, resulting in 11,296 investigations where 6,920 were substantiated. Of these, 3,119 protective applications were sought. If 70 percent of notifications do not result in an investigation it suggests that child protection is being overwhelmed by inappropriate notifications. There have been no major reforms in the way child protection processes notifications to suggest that current data would be any different.

Professionals and the general public should be better informed about when to notify child protection of their concerns. This will not necessarily be easy to do because while we want to raise the community awareness of child abuse and neglect, we also want the community to assess the situation against a threshold for reporting. However, other commentators argue that the level of reporting compared to the levels of substantiated cases is not the problem; rather we should concentrate on the number of abuse and neglect cases that are not reported.[14] No matter which side of the argument you support, there is consensus that improved screening processes are required across the board.

Our family violence staff also report that Child Protection too often dismiss notifications made by family violence services. We believe this results from Child Protection's lack of understanding of the link between family violence and child abuse, or the impact of family violence on children. Too often notifications by family violence practitioners are dismissed because one parent (usually the mother) is acting protectively without any regard to the potential risk of the perpetrator to the family. This results in the family violence service being left with the responsibility and expectation to monitor the risk to children. In some cases this is not possible, especially when women withdraw and return home to an abusive partner. We strongly

12 Bradshaw DJ, ‚Over reporting and underreporting of child abuse and neglect are twin problems›. In Loseke DR, Gelles RJ & Cavanaugh, (eds) (2005) *Current Controversies on Family Violence*, Sage Publications, California. pg. 285

13 http://www.cyf.vic.gov.au/child-protection-family-services

14 Finkelhor D, The Main Problem is Underreporting Child Abuse and Neglect, In Loseke DR, Gelles RJ & Cavanaugh, (eds) (2005) Current Controversies on Family Violence, Sage Publications, California. pg. 285

recommend that notifications made by family violence practitioners are treated differently to those of the general public and other professionals. Like child protection worker, family violence workers must assess the risk of lethality. It is essential that child protection assessments include the family violence risk assessment, as this provides vital information to support an assessment of the entire risk to the child.

One way to improve child protection intake processes is to ensure that intake staff are the most skilled and experienced staff. We understand that child protection has serious problems around staff recruitment and retention. However, only senior staff with at least two years experience should be employed at the intake and investigation levels — it is not a place for new graduates.

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

Family preservation must continue to be the first objective. However there are circumstances where this objective cannot be met. We need to ensure that when an assessment finds that it is unsafe for children to remain with their carer/parent/families, this follows appropriate checks and balances to ensure that the decision is the right decision.

Some decisions about where children are placed are problematic e.g. Family violence services have great concerns about the placement of a child with a perpetrator of family violence, given the impact on the child of witnessing that violence. We understand that some victims of family violence may not be suitable placements for children immediately following violence, however over time and with appropriate support many will be able to take up their parental responsibilities.

Homelessness services should never be the exit plan for adolescents leaving state care. The government as a ‘good parent’ must introduce new systems that better plan children’s exit from state care. Exit plans must begin years, rather than weeks, before the child’s sixteenth birthday. This could include measures such as providing the details of a person to contact within the Department (or a contracted agency) that a young person can call when things don’t go to plan. In 2011 many parents continue to support their children into adulthood, with children of this generation remaining at home into their middle twenties. How do we set up similar safety nets for children in state care? When faced with no alternatives children forced to leave state care might return to their birth families and live in the environment that they were initially removed from.

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?

Most protocols across the state could be strengthened and would benefit from further resourcing.

These include:

a) Think Child Agreement - Family Violence Services - Child FIRST/Family Services - Child Protection Think Child Partnership Agreement *North and West Metropolitan Region (August 2010)*

This is a state-wide agreement adopted by the North West Metropolitan Region. This initiative was driven by the Department of Human Service Central Office.

Some of the priorities for action under this agreement are to:

- Work to develop collaborative intake processes, including a shared understanding of key risk assessment concepts and approaches to risk management used by the different sectors
- Develop and implement appropriate information-sharing practices between all parties, in the best interests of the child, consistent with the Children Youth and Families Act 2005, the Privacy Act, the Family Violence Protection Act 2008 and the Information Sharing Protocols
- Promote joint training opportunities in the Common Risk Assessment Framework (CRAF) and the Best Interests Case Practice Model Information sharing legislation and guidelines
- Maximise opportunities to work together in the best interests of the child, e.g. Agreed referral pathways, joint risk assessment, secondary consultation, collaborative case conferencing and co-case management

These key activities will continue to be developed in line with the agreement. The Western Region Think Child working group is currently mapping the intersections between Child Protection, Child FIRST, Family Services and Family Violence Services systems initially focussing on intake process.

(b) The Common Risk Assessment Framework is another example of how family violence assessment is being rolled out across sectors and this would be a key document to continue to develop to support the safety of adult victims and children. The framework was developed in consultation

with Victorian family violence service providers, police and courts and based upon international research. It is the linchpin of the integrated family violence service system in Victoria. It provides a common language for all agencies to talk about risk assessment and promotes a shared understanding of the issues underpinning family violence. Continuing to promote training in this area for all those involved in working with and protecting children would enhance their safety and wellbeing.[15]

(c) Employing community-based child protection workers is a very effective initiative and should be expanded to other relevant sectors such as the family violence sector. This process enhances collaboration between sectors and provides capacity building for both sectors involved. As mentioned previously, Women's Health West and Brimbank/Melton Child FIRST are exploring piloting the placement of a family violence outreach worker within the Child FIRST team one day a week.

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

Family violence does not easily fit within the statutory environment of child protection, Child FIRST and family services. This is primarily because there are two victims: one child and one adult. Generally the family violence service response has been set up to respond to intimate partner violence where the victims are generally women and the perpetrators generally men. Family violence services are divided by gender: women's services targeting victims of violence and men's services targeting perpetrators. Women are not only the victims of the violence; they are also mothers and primary care givers of the children. Therefore there are structural and philosophical problems to overcome between the statutory responses to child victims and adult victims of violence and abuse.

Mechanisms that support multi-agency responses to child abuse and neglect include:

Professional Development

1. Shared understanding of family violence and child abuse and neglect
2. Understanding of the respective service responses including legislative responsibilities and limitations
3. Developing climates within organisations that support collaborative practices e.g. recognition that one service response cannot tackle all aspects of both child abuse and family violence
4. Practice guidelines and clear identification of roles and responsibilities including their limitations

Child protection offices and workers should be located in the community e.g. Preston Office covers the whole North West Metropolitan Region. The more isolated child protection service is from the community and

15 www.familyviolenceservices.com.au/documents/fvs_risk_assessment_and_risk_management_framework.pdf

community organisations, the more likely it will be viewed as part of the problem rather than part of the solution.

It is critical that as part of the review of child protection that the organisational culture be diagnosed because evidence suggests that in addition to affecting the implementation of a 'new business strategy', organisational culture can affect organisational performance[16].

While we advocate for the continued development, implementation and strengthening of existing multi-agency and integrated responses we must also be aware that there is some evidence that multi-agency integrated responses and increased professionalization can have negative consequences on clients.[17] Clients can become marginalised and silenced if there are not adequate structures in place to ensure that the systems continue to be responsive to the clients they serve. Family violence workers have also expressed safety concerns with this increase in the number of agencies or workers involved in a case.

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

5.1 What is the most appropriate role of government and for non government organisations in relation to child protection?

Government

1. Government must remain the 'parent' of a child when the child has no other or there is no one who is appropriate to fulfil this role.
2. Government must be responsible for the development of child protection policy and legislation.
3. Child protection must remain a government agency that is responsible through legislation to investigate, develop case plans and manage and monitor the safety of children.
4. Government must monitor out of home care e.g. foster care
5. Government must provide legal representation to all parties (Department of Justice)
6. Government must provide housing (bricks and mortar e.g. public housing system)

Non Government - Not for profit

1. Provide support services including family support, adult support and children's support
2. Recruit, train and provide support to volunteer foster parents
3. Provide auxiliary services e.g. homelessness, drug and alcohol, mental health and family violence services

16 Waddell DM, Cummings TG & Worley CR (2004) Organisation development and change. Thomson, Melbourne.

17 Cathy Humphries and Nicky Stanley (2006) Domestic Violence and Child Protection: Directions for Good Practice, Jessica Kingsley Publishers, London

Non Government - For Profit

It is important that accountability and responsibility for the health and wellbeing of children is clear. This may not be best achieved within a 'for profit' regime. If 'for profit' agencies are contracted to provide services on behalf of the government they must have stringent practice guidelines imposed through accreditation or registration mechanisms. This includes clear guidelines about where 'parental' responsibility sits and accountability mechanisms such as for the purchase of psychological services, especially psychological testing and reporting. Importantly, these services should be tested against criteria's of 'expert knowledge or specialisation' for example childhood trauma and family violence.

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Women's Health West Annual Report 2009-2010